Pennsylvania Employee Enrollment

(Please fill out entire application to avoid processing delay)

American Medical Security Life Insurance Company℠
P.O. Box 19032, Green Bay, WI 54307-9032
(920) 661-1111 • (800) 232-5432

Applicant Social Security Number ☐☐☐ – ☐☐ – ☐☐☐☐

Group No. ☐☐☐☐ – ☐☐☐☐☐☐

Applicant Information

Employer Name	Employer Address (If more than one location)
Last Name	First Name / Initial
❑ Single ❑ Married	Address / City / State / ZIP / County
Home Phone # ☐☐☐ – ☐☐☐ – ☐☐☐☐	Gender ❑ M ❑ F / Date of Birth / / / Height / Weight
Beneficiary Name	Last / First / Initial / Relationship
Beneficiary Address	City / State / ZIP
Date Employed Full Time / / / Average Hours Worked Per Week / Annual Salary $	Occupation Are you an independent contractor? ❑ Yes ❑ No

Family Information (Only for those applying).

First Name & M.I. (last name if different)	Gender	Date of Birth	Height	Weight	Social Security No.	Primary Care Physician's Name
Spouse:	❑ M ❑ F	/ /			/ /	
Child:	❑ M ❑ F	/ /			/ /	
Child:	❑ M ❑ F	/ /			/ /	
Child:	❑ M ❑ F	/ /			/ /	
Child:	❑ M ❑ F	/ /			/ /	

Dependents (age 19 and older) attending school full-time, include name of dependent, name/address of school, and no. of credits:____________________________

____

Eligibility and Other Insurance Information

❑ Yes ❑ No **Currently, are you working full-time? If no, explain** ____________________

❑ Yes ❑ No **Do any family members intend to keep other insurance coverage in addition to coverage under this policy? If yes, list family members:** ________

____

List the name of the other insurance company(ies) and the policy number(s): ____________________

List family members covered by Medicare and their effective date: ____________________

Coverage and Change Request Information

Medical: ❑ Employee ❑ Family ❑ Employee/Spouse ❑ Employee/Child(ren) Dental: ❑ Employee ❑ Family ❑ Employee/Spouse ❑ Employee/Child(ren)

Name of medical plan you have selected: ____________________ Short Term Disability/Dental Plan Selection(s):____________________

Network Name:____________________ Short Term Disability (Weekly Income) Benefit: ❑ Yes ❑ No $______________

Change request: ❑ Marriage ❑ Divorce ❑ Adoption ❑ Returning to school full-time ❑ Court Order Date of event : (you may be required to provide proof of event)

Attach a written and signed statement by the employer for a requested coverage effective date. Effective date may not be guaranteed.

Voluntary Coverages available, if employer sponsors these options: ❑ Yes ❑ No Voluntary Term Life and AD&D Insurance Benefit $ ___________

Waiver (Please complete if you are waiving medical or dental coverage.)

I waive medical coverage for: ❑ Self (and dependents) ❑ Spouse ❑ Dependents	Please state reason for waiving coverage: ______________
I waive dental coverage for: ❑ Self (and dependents) ❑ Spouse ❑ Dependents	Qualifying Coverage__________ Other ______________

If I have waived coverage for myself and/or my dependents (including my spouse) because of other health insurance coverage, I may in the future be able to enroll myself and/or my dependents in the policy, provided that I request enrollment within 31 days after my other coverage ends because of involuntary loss of other coverage (divorce, death, legal separation, termination of employment, reduction in number of hours of employment). In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll my dependents, provided that I request enrollment within 31 days after the date of the event. I further understand that if I am considered a late enrollee, I may be declined from coverage, excluded from coverage for a period of time, or subject to pre-existing limitations as defined in and where permitted by law, and I may be required to provide, where allowed by law, Medical History satisfactory to American Medical Security Life Insurance Company (AMS), for myself and/or my dependents. I further understand that if this form is submitted after the enrollment period, and I am approved for coverage, a longer limitation may apply to pre-existing conditions disclosed herein.

Depending upon state law, this information may be submitted as evidence of insurability.

REQUIRED MEDICAL INFORMATION

1. ❑ Yes ❑ No Are you or any eligible dependent disabled, hospital confined, or pregnant?
2. ❑ Yes ❑ No In the last five years, have you or any eligible dependents incurred claims in excess of $2,500?
3. ❑ Yes ❑ No Within the past five years, has any person to be insured been diagnosed or treated by a physician or member of the medical profession for acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?
4. ❑ Yes ❑ No Is any person to be insured receiving treatment, taking medication, or been advised of a condition that will require attention or routine follow-up in the next 24 months?
5. ❑ Yes ❑ No Within the past five years, has any person to be insured been diagnosed, had symptoms, had testing completed, had treatment, taken medications or had routine follow up for any of the following: Cancer/Tumor, Diabetes, Heart/Blood/ Vascular Disorder, Kidney Disorder, Liver Disorder, Neurological Disease, Respiratory/Lung Disorder, Stroke, Systemic Lupus/Multiple Sclerosis, Transplants, or Mental or Emotional Disorder?

Provide details to "YES" answers in the chart below. (If more space is needed, attach an additional sheet of paper, sign and date it.)

Note: For groups of 2-14 medical lives & underwritten add-ons/changes, completion of the Add'l Medical History section is needed to complete processing. If not applicable, continue on with Prior Medical/Dental Coverage section.

ADD'L MEDICAL HISTORY

1. Have you or any eligible dependent ever been declined, postponed, ridered, or rated up for medical, disability, or life insurance with another insurance carrier? ❑ Yes ❑ No
2. Within the past five years, has any person to be insured ever had any symptoms, diagnosis, consultation, treatment, or taken any medication or received counseling for…

A. Alcohol/Drug Abuse ❑ Yes ❑ No
B. Arthritis/Back/Joint Disorder ❑ Yes ❑ No
C. Asthma/Tobacco Usage ❑ Yes ❑ No
D. Blood Disorder ❑ Yes ❑ No
E. Breast Disorder or Breast Implants ❑ Yes ❑ No
F. Congenital Disorder or Deformity ❑ Yes ❑ No
G. Digestive/Eating Disorder ❑ Yes ❑ No
H. Ear/Eye Disorder ❑ Yes ❑ No
I. Epilepsy/Seizures ❑ Yes ❑ No
J. Genital/Urinary Disorder ❑ Yes ❑ No
K. High Blood Pressure ❑ Yes ❑ No
L. Infertility ❑ Yes ❑ No
M. Muscle Disorder/Neurological Disease ❑ Yes ❑ No
N. Skin Disease ❑ Yes ❑ No
O. Thyroid/Adrenal Disorder ❑ Yes ❑ No
P. Tuberculosis/Hepatitis A, B, or C ❑ Yes ❑ No
Q. Sleep Apnea ❑ Yes ❑ No
R. Systemic Infection ❑ Yes ❑ No

Provide details to "YES" answers in the chart below. (If more space is needed, attach an additional sheet of paper, sign and date it.)

Question/Letter	Name	Illness/Impairment	Dates Treated	Medications/Treatment/Surgery/Treating Physician

Prior Medical/Dental Coverage Information

Medical: If you are enrolling in a medical plan that is subject to Federal and/or state insurance small group reform laws, you may be eligible for a pre-existing condition limitation credit. Failure to provide the following information may result in a delay of benefits. Please attach any Certificate(s) of Creditable Coverage or other similar proof of coverage you have received.

❑ Yes ❑ No Have you or any dependents applying for coverage been covered by this employer's prior group medical plan?

❑ Yes ❑ No Have you or any dependents applying for coverage been covered by any medical plan other than this employer's prior group plan? If yes:

Insurance Company Name ______________ Phone # ______________ Policy/Group #________

Termination Date__________ Effective Date __________ Reason for Termination__________

Who was covered? ______________

Type of Plan: ❑ Prior Employer Group Plan ❑ Spouses Employer Group Plan ❑ Individual Policy ❑ Other ______________

Dental: If you are enrolling on a timely basis after the effective date of this employer's dental plan, you may be eligible for credit toward plan waiting periods. Failure to provide the following information may result in a delay of benefits.

Insurance Company Name ______________ Phone # ______________ Policy/Group #________

Termination Date__________ Effective Date __________ Reason for Termination__________

Who was covered?______________ Did plan include orthodontia benefits? ❑ Yes ❑ No

SIGNATURE REQUIRED – EMPLOYEE AGREEMENT

I understand that the above answers will be relied upon by American Medical Security Life Insurance Company (AMS) in the issuance of a certificate of insurance. I declare all statements contained in this entire form are true and correct and that no material information has been withheld or omitted. I understand and agree that AMS is not bound by any statement made by or to any agent unless written herein. I agree that no insurance will be effective until the date specified by AMS in the certificate of insurance. If I am now waiving medical and/or dental coverage for myself and/or for my dependents, I have read the entire Waiver provision, and understand the enrollment requirements if I make request for such coverage at a later date.

To assist AMS with determining my creditable coverage, I authorize any insurance company, third party administrator, plan administrator or other authorized carrier, to release to AMS, certificates of creditable coverage and all such information.

I authorize my employer to deduct the necessary contribution toward the premium. I reserve the right to revoke this deduction authorization at any time upon my written notice. This application will be part of the contract. Coverage is effective only after approval by AMS and satisfaction of any probationary period.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. Unless all pages are attached and completed, this will not be considered as a complete application. **Information on the application is valid for a maximum of 60 days from the date of signature.**

- I also hereby acknowledge receipt of the "Protecting Your Privacy" and "Protecting Your Health Information" notices. I understand that I may request an additional copy of these notices at any time.

Applicant Signature X ______________________________ **Date (required)** ____________

If signed by a representative of applicant, please indicate the representative's authority to act on behalf of applicant.

____

Spouse Signature X ______________________________ Date (required) ____________
(If spouse is to be insured)

SIGNATURE REQUIRED/AUTHORIZATION TO USE MEDICAL INFORMATION FOR ENROLLMENT

Please clearly print all information.

I hereby authorize those physicians, medical practitioners, hospitals, clinics, veterans administration facilities, medical information services, urgent care facilities, and other medical or medically related entities, insurance or reinsurance companies, and consumer reporting agencies that have information available as to the present or former physical health condition, including drug or alcohol abuse, and/or treatment of me or my dependents to release any and all such information, including, but not limited to, medical records, health-care provider notes, laboratory tests and results, diagnoses, treatment, and prognoses. I understand the information obtained by use of this authorization may be used to determine eligibility for issuance of health coverage and eligibility for benefits under an existing policy/certificate of insurance for me and my dependents. This authorization is not applicable to psychotherapy notes.

I agree that a photographic copy of this authorization shall be as valid as the original and that this authorization shall expire 15 months after the termination of any coverage I obtain. I understand that I may request a copy of this authorization. I understand that I may revoke this authorization at any time in writing unless action has been taken in reliance on my authorization. Because this authorization is given as a condition of obtaining insurance coverage, my revocation will not prevent American Medical Security Life Insurance Company (AMS) from the right to contest a claim under the policy if another law so allows. Should me or my dependents refuse to sign this authorization, I understand it may affect my enrollment in the benefit plan. All pages must be attached and complete, including this authorization for the application to be considered complete. Incomplete applications may be rejected.

Customer Signature X ______________________________ Date ____________

If signed by a representative of applicant, please indicate the representative's authority to act on behalf of applicant.

____

Spouse Signature X ______________________________ Date ____________
(If spouse is covered)

Signature of Each Covered Dependent Age 18 and Over:

X____________________Date____________ X ____________________ Date ____________

X____________________Date____________ X ____________________ Date ____________

P.O. Box 19032, Green Bay, WI 54307-9032
(920) 661-1111 • (800) 232-5432

PROTECTING YOUR PRIVACY

American Medical Security Group, Inc. (AMS)* strives to protect the personal financial information of current and former customers.

We want you to know that the information you provide is safe and used responsibly. To maintain the level of service you expect from AMS, we may need to share limited personal financial information within our family of companies and with selected business partners. ***You can be certain that protection of your personal financial information is one of our priorities.***

SAFEGUARDS IN PLACE AT AMS

We use data encryption and storage technology that protect your sensitive personal information. At AMS, we have administrative, technical, and physical safeguards in place to ensure privacy. These include:

- Policies and procedures for handling information.
- Limited access to facilities where information is stored.
- Requirements for third parties to contractually comply with privacy laws.
- Continuous review of company security practices.

We provide training on confidentiality and customer privacy to ensure employees are dedicated to keeping your personal information safe and secure.

YOUR PROTECTION ON THE INTERNET

We collect limited data from our Internet site, such as the date, time, and areas of our site that are visited. This general information helps us improve our site and makes it easier and more convenient for you to use.

If we ask for personal information on the Web site, you will enter a "secure" mode. The following security features keep your data safe:

- A secure server using 128-bit encryption and authentication technologies, verified by Verisign, Inc. (a leading provider of secure, online certificates).
- Site design to limit display of customer information to only what is necessary.
- Specific user names and passwords to protect sensitive information.

TYPES OF INFORMATION WE GATHER AND USE

In administering health benefit plans, we gather and maintain information that may include nonpublic personal information:

- From applications, supporting documents, and other forms (e.g., phone/Social Security/account numbers, income, and employment history).
- About your transactions with us or our affiliates (e.g., payment history and other account information).
- From business partners, vendors, and service companies (e.g., payment processing center or credit union).
- From health-care providers, insurance companies, and third-party administrators (e.g., medical records, claim payment information).

At times, we need to disclose your nonpublic, personal information to our business partners as necessary to affect, administer, or enforce our transactions with you. We may also share all of this information with companies that perform services on our behalf, provided they contractually agree to keep the information confidential.

IN CERTAIN STATES, YOU MAY BE ABLE TO ACCESS AND CORRECT PERSONAL INFORMATION

You may have the right to access and correct personal information we have collected about you. Personal information includes information that can identify you (e.g., your name, address, Social Security number, etc.).

OUR COMMITMENT TO YOU

You're a valued customer, and the information you provide to us is safe and used responsibly. We'll continue to maintain your privacy and provide you with information about how we share your non-public personal financial information.

If you have questions about our privacy guidelines, please call us toll-free at **(800) 232-5432, Ext. 15201** or visit the Web site at:

www.eAMS.com and click on Privacy Policy.

Customer service representatives are available 24 hours a day, 365 days a year.

P.O. Box 19032, Green Bay, WI 54307-9032
(920) 661-1111 • (800) 232-5432

*AMS includes American Medical Security Life Insurance Company and its affiliates. It also includes a contracted and non-affiliated entity, Carolina Benefit Administrators, Inc.

NO-0461-00-H-00 1/05

Protecting Your
Health Information

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

American Medical Security Group, Inc., affiliates, and subsidiaries, collectively AMS*, responsibly use your individually identifiable health information (referred to as "confidential information"). Confidential information includes information that is created or received by a health-care provider, health plan, employer, or health-care clearinghouse. It also includes information related to your past, present, or future physical/mental health and payment for the provision of your health care.

AMS may use and/or disclose your confidential information without your authorization for the following purposes:

- Rating and other activities relating to the placement or renewal of health benefits.
- Billing, claims payment, review of health-care services, and the management of health-care and related services by health-care providers.
- Providing appointment reminders or information about treatment alternatives, other health-related benefits, and services.
- Providing treatment (coordination and management of health-care related services), payment, or health-care operations.

We may also use and/or disclose your confidential information without your authorization as permitted or required by law (e.g., public health authority or Food and Drug Administration matters; public health intervention or investigation purposes; evaluation relating to the medical surveillance of the work place; work-related illnesses or injuries; civil, administrative, or criminal investigations and/or inspections; judicial and administrative proceedings; local, state, and federal law enforcement purposes). We may also use it for disclosures to the sponsor of a group's health plan, health insurance issuer, or HMO.

Your *authorization is required* for AMS to use your confidential information to determine eligibility for enrollment and continued eligibility under your health plan. An authorization must also be submitted if you choose to appoint individuals, other than those allowed by law, to receive information about you. You may revoke the authorization in writing at any time unless we are acting or have acted in reliance on an existing authorization from you.

You have the right to:

- Request an alternate address or other method of contact if you believe that sending your confidential information to its original location may endanger you.
- Inspect and copy your confidential information.
- Request restriction on certain uses or disclosures; however, these restrictions are subject to agreement by AMS.
- Receive an accounting of the disclosures we make involving your confidential information.
- Amend your confidential information (in limited situations).

AMS will maintain the privacy of confidential information as required by law and by the notice currently in effect. AMS is also required to provide this notice of our legal duties and privacy practices related to protected health information. This notice is effective April 1, 2003. We reserve the right to make changes or revisions to the terms of this notice and will send you a new notice if any material changes are made.

If you believe your rights have been violated, you may contact AMS or the secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint. You may send information to AMS at the address listed below:

American Medical Security Life Insurance Company
Attn: Customer Service Department/Privacy Officer
P.O. Box 19032
Green Bay, WI 54307-9032

If you wish to contact the Department of Health and Human Services, please call us and we'll provide you with the appropriate address.

You have the right to receive another paper or electronic copy of this notice. To request another copy or to get more information, you may call AMS at:

(800) 232-5432, Ext. 15201

Or visit the Web site at:

www.eAMS.com

Customer service representatives are available to assist you 24 hours a day, 365 days a year.

*AMS includes American Medical Security Life Insurance Company and its affiliates. It also includes contracted and non-affiliated entities, including Carolina Benefit Administrators, Inc. and Health Plan Administrators, Inc.

NO-0459-00-H-00 1/05

Federal Women's Health and Cancer Rights Act of 1998

The federal Women's Health and Cancer Rights Act of 1998 requires that benefits must be provided for:

- Reconstruction of a surgically removed breast;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment for physical complications from all stages of mastectomy, including lymphedemas.

These benefits are subject to applicable terms and conditions under your health plan, including copayments, deductible, and coinsurance provisions. They are also subject to medical insurance limitations and exclusions.

This notification is a requirement of the act. If you have any questions, our customer service representatives are ready to assist you 24 hours a day, 365 days a year at (800) 232-5432.

American Medical Security Life Insurance Company is the underwriter for fully insured products and administrator for self-funded plans.

P.O. Box 19032, Green Bay, WI 54307-9032
(920) 661-1111 • (800) 232-5432

GN-2426-00-H-00 1/05

CONSENT TO RELEASE MEDICAL INFORMATION

(Optional Consent – You are not required to sign.)

Please clearly print all information.

This Consent will permit any physician, medical practitioner, hospital, clinic, Veterans Health Administration facility, insurance/reinsurance company, or other appropriate entity having information about the onset or cause, diagnosis, treatment, prognosis related to any physical or mental condition, including drug or alcohol abuse, communicable disease, accident, or injury of you or your minor children, as indicated below, to release to American Medical Security Life Insurance Company or its legal representatives any and all such information. The information you consent to release may include confidential information or a personal medical history for you or your minor children. This information will be used solely for the determination of benefits on the claim and will be held in strict confidence.

As required by state regulations, we need to inform you that the information you authorize for release may include documentation regarding the presence of a communicable disease or venereal disease. This information may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, human immunodeficiency virus (HIV), and acquired immune deficiency syndrome (AIDS).

If the documentation received includes information regarding domestic abuse/violence, we cannot use this as a basis for denying, refusing to issue, or canceling your insurance coverage. Nor can this information be used as a basis to restrict or exclude coverage or benefits under your plan. We want to assure you that we are in no way indicating that your records will include this type of information.

You may revoke this Consent at any time upon your written request. It will expire automatically following six months from the date of signature below, except in North Carolina and Wisconsin. In North Carolina this Consent is valid for the term of the policy. In Wisconsin this Consent is valid for the term of the policy or while the claim(s) is pending, whichever is longer. A copy of this document shall be as valid and effective as the original and is available upon request at any time.

The nature of the information consented to be disclosed may include, but is not limited to, the following:

- Anesthesia Notes
- Consult Report
- Dental Records
- Drug/Alcohol/Substance Abuse Records
- Discharge Summary
- History and Physical
- Hospital Records
- Medical Records
- Nurses' Notes
- Operative Report
- Pathology/Lab Reports
- Pharmacy Records
- Physician's Orders
- Progress Notes
- Therapy Records
- Police/Accident Report

If you or any of your dependents have used another name (for example, maiden name, stepchild, etc.), please write the name(s) here:

____

Customer Signature   Customer Social Security Number   Date

For EarlyCare, signature must be the child's parent or legal guardian if customer is not of legal age.

If signed by a representative of customer, please indicate the representative's authority to act on behalf of customer.

____

Spouse Signature (if spouse is covered)   Date

Signature of Each Insured Dependent Age 18 and Over

X ________________ Date   X ________________ Date

X ________________ Date   X ________________ Date

For copies of this consent, visit www.eAMS.com and click on Privacy Policy or call (800) 232-5432, Ext. 15201.

Group Number   Certificate Number

For office use only.

P.O. Box 19032, Green Bay, WI 54307-9032
(920) 661-1111 • (800) 232-5432
www.eAMS.com

AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION FOR CUSTOMER SERVICE

(Optional Authorization – You are not required to sign)

Please clearly print all information.

For the purpose(s) of customer service and related activities, I hereby agree, on my behalf and on behalf of my minor dependents, that information available regarding coverage or any claim regarding me or my minor dependents may be released by American Medical Security Group, Inc. (AMS)* to me, my spouse, my parents (for dependents age 18 or over), my medical providers, my plan sponsors/employers, my agent(s) of record, as applicable, or as may be otherwise lawfully permitted, or as I may further authorize in the box below.

OPTIONAL Additional Authorized Individuals – Please Print Clearly.
I additionally authorize the following individual(s) to receive the above-named information.

Full Name ____________________ Relationship to customer ____________________

Full Name ____________________ Relationship to customer ____________________

Please Note: An authorization is not needed for disclosures related to my or my minor dependents' treatment, the payment for such treatment, or related health-care operations as defined under 45 CFR parts 160 and 164, Standards for Privacy of Individually Identifiable Health Information. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the authorized recipient and may no longer be protected by state or federal law. This authorization does not apply to psychotherapy notes.

I agree that a photographic copy of this authorization shall be as valid as the original and that this authorization shall expire 15 months after the termination of any coverage I obtain (In Georgia and Texas, 24 months from the signature date). I understand that I may request a copy of this authorization. I understand that I may revoke this authorization at any time in writing unless action has been taken in reliance on my authorization. I understand that I may refuse to sign this authorization. Should I choose to sign this authorization, I understand that I have the right to request access to my protected health information that may be used or disclosed.

Information Needed To Identify Your Plan - Please Print Clearly:
Primary Customer Identification Number: ____________________
(See ID card for Customer Identification Number)

Customer Signature ____________________ Date ____________________ Print Customer Full Name ____________________

For EarlyCare, signature must be the child's parent or legal guardian if customer is not of legal age.

Spouse Signature (if spouse is covered) ____________________ Date ____________________

Signature of each Covered Dependent age 18 and over

Dependent Signature ____________________ Date ____________________ Dependent Signature ____________________ Date ____________________

If signed by a legal representative of customer, please indicate the legal representative's authority to act on behalf of customer.

Legal Representative Signature ____________________ Authority ____________________ Date ____________________

For copies of this authorization, visit www.eAMS.com and click on Privacy Policy or call (800) 232-5432, Ext. 15201. You may fax authorizations to (920) 661-4415 or mail them to American Medical Security, Attn: Imaging Department, P.O. Box 19032, Green Bay, WI 54307-9032.

Group Number ____________________ Certificate Number ____________________
For office use only.

**AMS includes American Medical Security Life Insurance Company and its affiliates.*
It also includes a contracted and non-affiliated entity, Carolina Benefit Administrators, Inc.

P.O. Box 19032, Green Bay, WI 54307-9032
(920) 661-1111 • (800) 232-5432
www.eAMS.com