ESSENTIAL BENEFIT ADMINISTRATORS

SECTION 1: Applicant Information

Last Name:	Effective Date:		Plan Name:
First Name:	Date of Birth (DOB):		
Sex: ❑ M ❑ F	SS#:	U.S. Citizen: ❑Y ❑N	Legal Resident: ❑ Y ❑N
Home Phone #:	Work Phone #:	Best Time to Call: a.m. p.m. ❑ Work ❑Home	
Street Address:	City:	State:	Zip:
Height:	Weight:		

SECTION 2: Coverage Information

Please check all that apply. I wish to enroll in the following plan for: ❑ Myself ❑ and Spouse ❑ and Child(ren)		
❑ MEC Plan	❑ MEC Plus	❑ MEC Premium Plus
Advantage Care: ❑ Level 1	❑ Level 2	❑ Level 3

SECTION 2a: Prior Insurance Coverage Information – Please include a Certificate of Creditable Coverage from your previous insurance provider, if available, to avoid delay in the payment of your claim(s).

Have you or any of your dependents been covered by any **other MEDICAL** plan besides your current employer's plan within the past 12 months (This includes any other Employer Sponsored Medical Plan, Medicaid, Medicare, Champus, Tricare, etc.) ❑No ❑Yes ❑Yes, due to COBRA. If yes, including yes due to COBRA coverage, answer all remaining questions in this section.			Name of Insurance Carrier:
Policy #:	Effective Date:	Term Date:	Policy Holder's Name:
Member ID #:	Employer:	Covered on Policy: ❑Myself ❑Spouse ❑Child(ren) (list names):	

SECTION 2b: Other Insurance Coverage Information

Will you or any of your dependents be covered under another MEDICAL plan while covered under this Key Healthy Partners plan offered by your employer? (This includes Medicaid, Medicare, Champus, Tricare, etc.) ❑No ❑Yes. If yes, answer all remaining questions in this section.			Name of Insurance Carrier:
Policy #:	Effective Date:	Policy Holder's Name:	
Member ID #:	Employer:	Covered on Policy: ❑Myself ❑Spouse ❑Child(ren) (list names):	

SECTION 3: Dependent Information (list all dependents below that you are enrolling per the benefits above. Use additional page if needed.)

❑Spouse ❑Domestic Partner	Last Name:	First:	SS#:	DOB:	❑Male ❑Female	Height:	Weight:
❑Child	Last Name:	First:	SS#:	SS#:	❑Male ❑Female	Height:	Weight:
❑Child	Last Name:	First:	SS#:	SS#:	❑Male ❑Female	Height:	Weight:
❑Child	Last Name:	First:	SS#:	SS#:	❑Male ❑Female	Height:	Weight:
❑Child	Last Name:	First:	SS#:	SS#:	❑Male ❑Female	Height:	Weight:

If a court decree requires you to cover your dependent under this plan, SUBMIT that portion of the court decree with this enrollment form.

Health Eligibility Questions

Are you or any person(s) to be insured now pregnant, an expectant parent, in the process of adopting a child or undergoing infertility treatment?

❑ Yes ❑ No

Are you or your spouse or any person to be insured totally and permanently disabled and/or receiving long-term disability benefits?

❑ Yes ❑ No

In the last 12 months, has any proposed insured been recommended or scheduled for diagnostic testing, consultations, treatment, follow-up surgery that has not been completed?

❑ Yes ❑ No

Are you or any applicant over 300 pounds if male, or over 250 pounds if female?

❑ Yes ❑ No

For any of the following conditions within the last 5 years, have you or any person(s) to be insured received any abnormal test results, or medical or surgical treatment, or consulted a health care professional, or has medication been prescribed or recommended for:

- Heart disorder, excluding Mitral Valve Prolapse (MVP) or surgically corrected or closed Atrial Septal Defect (ASD)/Ventricular Septal Defect (VSD)
- Coronary Artery Disease (CAD), Heart Attack or had Heart Surgery
- Stroke Transient Ischemic Attack (TIA) or Carotid Artery Disease
- Peripheral Vascular Disease (PVD) or Peripheral Arterial Disease (PAD)
- Crohn's Disease or Ulcerative Colitis
- Liver disorders or Hepatitis B or C, excluding fully recovered Hepatitis A
- Kidney disorders, including kidney stones
- Emphysema, Chronic Obstructive Pulmonary Disease (COPD), Fibrotic Lung Disease or Primary Pulmonary Hypertension
- Diabetes, excluding Gestational Diabetes
- Cancer or Tumor, except Basal Cell Skin Cancer
- Alcoholism, Alcohol or Chemical Dependency, or Drug or Alcohol Abuse, or use disorder
- Acquired Immune Deficiency Syndrome (AIDS) or tested positive for Human Immunodeficiency Virus (HIV)
- Autism Spectrum Disorders, Autism, Asperger's Disorder, Rett's Syndrome, Pervasive Development Disorders or Pervasive Development Delay
- Multiple Sclerosis (MS)
- Tuberculosis (TB)
- Any condition that resulted in: a surgery or procedure whose purpose is to promote weight-loss

Insured's Name: _____

Insured's Signature: _____ Date: _____