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SIGNIFICA INSURANCE GROUP, INC.
GROUP HEALTH
ENROLLMENT APPLICATION

You, the employee, must complete the application in your own handwriting. Please print clearly using ink. You are solely responsible for its accuracy and completeness. All questions must be answered in full or the application may be returned to you, which may delay the effective date of your coverage.

Employee Information (Must be completed by employee) [] Employee Enrollment [] COBRA Enrollment Plan Selection _____

Form with fields for Last name, First name, MI, Marital status, Gender, Home address, Home phone, Work phone, City, State, ZIP, Social Security Number, Primary language, Email address, Date of birth, Height, Weight, Do you smoke?, Employer name, Occupation/Job title, Hire date, Hours worked per week.

Dependent Information (List only those eligible dependents who are enrolling)
If your spouse's last name differs, please provide marriage date: _____. If your dependent child is not legally adopted or is not the birth child of you and/or your spouse, please explain why the child is a dependent. If there is a custodial parent responsible for the care of anyone listed, please attach a copy of a power of attorney or other court-initiated document.

Table with 10 columns: Sex (M/F), Last name, First name, MI, Social Security Number, Height, Weight, Student/Disabled, Birthdate MM/DD/YY, Smoker (Y/N). Rows include Spouse and multiple Dependents.

Waiver I decline to apply for group health coverage for: [] Myself [] Spouse [] Dependent(s) [] Spouse and Dependent(s)
The reason for declining coverage is due to: [] Spousal Coverage [] Medicare/Medicaid [] Enrolled in other health insurance plan [] COBRA [] Other (please explain) _____

Special Enrollment Notice: If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact a customer service representative.

Employee Signature (ONLY IF WAIVING COVERAGE) _____ Date: _____

Other Medical Coverage (All questions must be answered.)
A. Do any persons on this application intend to continue other group coverage if this application is accepted? [] Yes [] No
If yes, name: _____ Insurance company: _____
B. Does any person applying for coverage have health insurance coverage? [] Yes [] No If yes, name: _____
Insurance company: _____ Type of coverage: [] Group [] Individual [] Other
C. Is any person applying for coverage eligible for Medicare? [] Yes [] No If yes, name: _____
If Medicare disability, explain why: _____

Group Term Life/AD&D Employee-Only Coverage (Complete this section only if your Employer is offering this coverage through Significa)
Beneficiary Full Name: _____ Beneficiary's Social Security Number: _____
Beneficiary's Date of Birth (mm/dd/yyyy): _____ Relationship to Applicant: _____
Beneficiary's Address: _____ State: _____ ZIP: _____

Please DO NOT INCLUDE any genetic information such as family medical history or any information related to genetic testing, genetic services, genetic counseling, or genetic diseases for which you believe that you may be at risk.

Health History

Please check "yes" or "no" to each question. Within the last five years, have you or any dependent been medically diagnosed or treated for any of the following conditions:

Yes	No	
		Cardiovascular/Heart/Circulatory/Stroke
		Diabetes/Endocrine Disorder/Thyroid
		Blood Disorder
		Cancer/Tumor
		Liver Disorder
		Central Nervous System Disorder/Epilepsy
		Kidney Disease
		Reproductive System Disorder
		Stomach or Intestinal Disease
		Lung Disease
		Mental Condition/Alcoholism/Substance Abuse

Yes	No	
		Muscular Disorder/Arthritis/Joint or Bone Disease
		Organ Transplant
		Has any person listed on this application ever been diagnosed as having AIDS or an AIDS-related condition or ever had a positive test result on an HIV test?
		Has anyone been medically advised to undergo surgery or hospitalization?
		Is anyone currently pregnant?
		If yes, is a multiple-birth expected?
		ADHD or Autism
		Other:

If you answered yes to any of these questions, please provide details below: (If additional space is required, please attach a separate sheet and be sure to date and sign that sheet.)*

Family Member/ Dependent	Condition/Diagnosis	List All Medication & Treatment	Physician's Name/ City & State	Dates Diagnosed	Still Under Treatment

Terms and Conditions

On behalf of myself and the dependents listed, I agree to, or with, the following:

- I authorize Significa Insurance Group, Inc. (Significa) and its affiliates to obtain, use and disclose my medical, claim or benefit records, including any individually identifiable health information contained in these records.
- I authorize any health care provider, pharmacy benefit manager, other insurer or reinsurer, hospital, clinic or other medical facility, health care clearinghouse, and any of their affiliates, representatives or business associates, to disclose my information to Significa and affiliates.
- I authorize the Social Security Administration to furnish to Significa medical or any other information acquired by it under Title XVIII of the Social Security Act (Medicare) to the extent necessary to process any claim under my agreement.
- I understand these records may contain information created by other persons or entities (including health care providers) as well as information regarding the use of drug, alcohol, HIV/AIDS, mental health (other than psychotherapy notes), sexually transmitted disease and reproductive health services.
- I understand the purpose of the disclosure and use of my information is to allow Significa and affiliates to make decisions regarding eligibility, enrollment, underwriting and premium risk rating.
- I further understand the information I authorize a person or entity to obtain and use may be redisclosed and no longer protected by federal privacy regulations.
- I understand this authorization is voluntary and I may refuse to sign the authorization. My refusal may, however, affect my ability to enroll in the health plan or receive benefits, if permitted by law.
- I understand I may revoke this authorization at any time by notifying Significa and affiliates in writing at the address provided, except to the extent that action has already been taken in reliance on this authorization.
- This authorization, unless revoked earlier, expires 30 months after the date it is signed.
- I understand that I am completing an application and that each response must be complete and accurate. I have a continuing obligation to report changes in health status (e.g. received medical advice, diagnosis, care or treatment) after I sign the enrollment form and before receipt of my identification card.
- I understand any untrue or incomplete information, statements or answers on this application (whether intentional or not), can result in the denial of a claim or rescission of coverage and may subject me to legal action by Significa.
- I have not given the agent or any other persons any health information not included on the application.
- I understand and agree that no agent or broker has the authority to: (1) bind Significa by making promises regarding eligibility, benefits, or the issuance of a policy; (2) waive any answer or any portion of any answer to any question on this application or any information Significa requests; (3) approve coverage; (4) make or alter any contract on behalf of Significa; or (5) waive or alter any of Significa's other rights or requirements. All contract terms must be in writing and signed or accepted in writing by an authorized representative of Significa to be binding on Significa.

- I understand that Significa and affiliates is not bound by any statements I have made to any agent or to any other persons, if those statements are not written or printed on this application and any attachments.
- I request the indicated group medical coverage for myself and, if the plan provides, for my dependents. I authorize any required premium contributions to be deducted from earnings.
- I understand and agree that my employer's application will determine coverage and that there is no coverage unless and until both this enrollment form and the employer application have been accepted by Significa. Even if this enrollment form is accepted, any intentional and material misstatements or omissions that amount to fraud may result in future claims being denied and my coverage under the policy being rescinded or reevaluated, as of the effective date, for eligibility and rating purposes except as otherwise provided by law. If coverage is issued, it will be based on full reliance on the information contained in this application.
- I understand and agree that, as described in the plan documents, when enrolled for medical coverage any pre-existing conditions for my spouse, dependents or myself may not be covered for 12-18 months.
- I understand that the applicable certificate or evidence of coverage will determine the rights and responsibilities of covered persons and will govern in the event they conflict with any benefits comparison, summary or other description of the plan.
- I have discussed the terms of this authorization with my spouse and competent adult dependents, if enrolling, and I have obtained their consent to those terms.
- I understand and agree that providers and vendors are independent contractors in private practice and are neither employees nor agents of Significa or its affiliates. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change.
- For life coverage:** I understand that being Actively at Work is a requirement for coverage. If I am not Actively at Work on the day this coverage would otherwise be effective, the effective date of this coverage will be the date of my return to Active Work. If I do not return to Active Work, I will not be covered. The terms "Actively at Work" and "Active Work" mean that an employee is performing the material and substantial duties of his occupation; is working the number of hours specified in the policy or plan document; and satisfies any other conditions required by the applicable group life policy.
- For your protection, Arizona law requires the following statement to appear on this form: Any person who knowingly presents false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

I have read all of the statements contained in this application, and declare by signing this application that I am an active, eligible, compensated, full-time employee and that the information I have provided is true and complete to the best of my knowledge. I have maintained a copy of this authorization for my records.

Signature

Date