KEY HEALTHY PARTNERS
Administered by KEY BENEFIT ADMINISTRATORS

Enrollment Application

Please Print Clearly in Blue or Black Ink

SECTION 1: Employee Information

Group Name:			Employee's Original Start Date:
Last Name:			Date you became a Full time Employee:
First Name:			Date of Birth (DOB):
Sex: ☐ M ☐ F	SS #:	U.S. Citizen: ☐ Yes ☐ No	Legal Resident: ☐ Yes ☐ No
Home Phone #:	Work Phone #:		Best Time to Call: a.m. p.m. ☐ Work or ☐ Home
Street Address:	City:	State:	Zip:
Height:	Weight:	No. Hours Work/per week:	Job Title:
Marital Status: ☐ Single ☐ Married (date__________) ☐ Divorced (date__________) ☐ Separated (date__________) ☐ Widowed (date__________)			
Please check one of the following: ☐ New employee[1, 2] OR ☐ Current employee newly eligible for benefits[1, 2] OR ☐ New Group Enrollment[2]			

[1]Attach a CERTIFICATE OF PRIOR CREDITABLE COVERAGE (CCC) from your previous insurance provider to avoid delays in the payment of your claims.

[2] Medical coverage will be effective after employer's waiting period has been satisfied.

SECTION 2: Coverage Information

Please check all that apply. I wish to enroll in Key Healthy Partners for: ☐ Myself ☐ and Spouse ☐ and Child(ren)	
☐ KeyGap coverage, if applicable	☐ Life coverage, if applicable (Separate life application may be required.)

SECTION 3: Prior Insurance Coverage Information

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 4: 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:

Last Name:	First:	SS#:	DOB:	❑Male ❑Female
❑Child ❑Disabled[4] ❑FT Student[4] ❑Court Ordered[5] **OR** ❑Step-Child who ❑Resides with me ❑ Is designated as a dependent on my Federal Income Tax Return				
Last Name:	First:	SS#:	DOB:	❑Male ❑Female
❑Child ❑Disabled[4] ❑FT Student[4] ❑Court Ordered[5] **OR** ❑Step-Child who ❑Resides with me ❑ Is designated as a dependent on my Federal Income Tax Return				
Last Name:	First:	SS#:	DOB:	❑Male ❑Female
❑Child ❑Disabled[4] ❑FT Student[4] ❑Court Ordered[5] **OR** ❑Step-Child who ❑Resides with me ❑ Is designated as a dependent on my Federal Income Tax Return				
Last Name:	First:	SS#:	DOB:	❑Male ❑Female
❑Child ❑Disabled[4] ❑FT Student[4] ❑Court Ordered[5] **OR** ❑Step-Child who ❑Resides with me ❑ Is designated as a dependent on my Federal Income Tax Return				
Last Name:	First:	SS#:	DOB:	❑Male ❑Female
❑Child ❑Disabled[4] ❑FT Student[4] ❑Court Ordered[5] **OR** ❑Step-Child who ❑Resides with me ❑ Is designated as a dependent on my Federal Income Tax Return				

[4]For full-time student or disabled dependents, SUBMIT appropriate documentation as proof of student or disabled status with this enrollment form.
[5]If a court decree requires you to cover your dependent under this plan, SUBMIT that portion of the court decree with this enrollment form.

MEDICAL HISTORY IMPORTANT:

All employees whether ENROLLING or DECLINING COVERAGE; must complete all questions below. Attach additional page(s) if needed. Incomplete information will result in a delay of the application process.

SECTION 5: within the past TEN (10) years, have you or any of your listed dependents had symptoms, conditions, received medical advice, been diagnosed or treated by a physician for any of the conditions listed below? Please answer all condition with **"YES" or "NO".**

CONDITIONS	YES	NO	CONDITIONS	YES	NO	CONDITIONS	YES	NO
AIDS / ARC / HIV			Crohn's Disease			Liver Disorder		
Alcohol or Drug Dependency			Depression / Anxiety			Lung Disorder		
Allergies			*Diabetes / Pre-Diabetes			Mental / Nervous / Psych. Disorder		
Alzheimer's Disease			Diverticulitis			Metabolic Syndrome		
Anorexia / Bulimia			Down's Syndrome			Multiple Sclerosis		
Arthritis			Emphysema			Neurological Disorder		
Asthma			Epilepsy			Paralysis		
Atrial Fibrillation (Irregular Heartbeat)			Gastric / Peptic Ulcer			Parkinson's Disease		
Auto-immune Disorder			GERD			Peripheral Artery Disease		
Back / Spinal Disorders			Heart Attack			Polymyalgia Rheumatica (PMR)		
Blood Disorders			Heart Blockage			Skin Disorder / Acne		
*Blood Pressure / Hypertension			Heart Bypass Surgery			Sleep Apnea		
Bowel / Stomach Disorder			Heart Disorder			Spina Bifida		
Cancer / Leukemia / Melanoma			Hemophilia			Stroke		
Cerebral Palsy			Hepatitis			Thrombo-embolic Disease		
Chronic Bronchitis			Hernia			Transplants		
Chronic Obstructive Pulmonary Disease (COPD)			High Risk Pregnancy			Tuberculosis		
Chronic Renal Insufficiency (CRI)			Hyperlipidemia (High Cholesterol)			Tumors / Growths / Cysts		
Congenital Disease / Defect			Hyperthyroidism (Graves Disease)			Ulcerative Colitis		
Congestive Heart Failure			Hypothyroidism (Goiter)			Venereal Disease		
Coronary Artery Disease			Kidney / Urinary Disorder			Any other condition not listed:		

***If you or any of your dependents included on this enrollment form are being treated for Hypertension/High Blood Pressure or Diabetes, please provide the following information:**

List Last 3 Blood Pressure Readings:

Applicant Name:_____**Current**_____**6Mo**_____**1Yr**_____

Additional Applicant Name:_____**Current**_____**6Mo**_____**1Yr**_____

Diabetes Mellitus (Type): ☐ **Type 1 Juvenile Diabetes** ☐ **Type 2 Adult Onset Diabetes ……** ☐ **Yes** ☐ **No**

If "Yes", check treatment: ☐ **Diet Controlled** ☐ **Oral Medications** ☐ **Insulin** ☐ **Insulin Pump** **Date of Onset:**_____/ _____/_____

Include your last Hemoglobin A1c Reading and Date: _____ _____/ _____/_____

SECTION 6:

1) ☐ YES ☐ NO	Is any applicant currently under a doctor's care, receiving treatment, taking medication or being advised of a condition that will require medical/surgical care or treatment in the future?
2) ☐ YES ☐ NO	In the past 5 years, have you or any of your dependents been examined/treated by a doctor, been hospitalized/operated on for any condition not listed above?
3) ☐ YES ☐ NO	Is any person to be covered currently pregnant? If "Yes", what is the due date? ___/___/___
4) ☐ YES ☐ NO	Have you and/or any of your dependents used any form of tobacco within the past 12 months? ☐ Myself ☐ Spouse ☐ Child(ren)

SECTION 7: Provide Details to **ALL "Yes" answers from Sections Five & Six**. **You must list ALL Medications prescribed in the past 24 months for you and any dependents.** Attach additional pages if necessary. Additional Health Questionnaires may be required.

Person (First Name)	Medical Condition / Diagnosis	Treatment / Medication (Rx) / Dosage / Degree of Recovery	Start Date	End Date	Name/Address of Physician or Hospital	Phone # of Physician or Hospital

Check One or Both, Enrolling and/or Declining Yourself or Your Dependents:

☐ ENROLLING: Employee Signature: Sign, date, and return this form to your employer's HR department to implement the above enrollment/changes.

I hereby apply for participation in my Employee Health & Welfare Benefit Plan for myself and/or my dependents listed above and agree to abide by the terms, provisions and limitations as outlined by the Plan Sponsor in the issuance of the Summary Plan Description. 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 that any misstatements or failure to report information which is material to my qualification and participation may be used as a basis for rescission of my participation and/or denial of payment of claim. It is a crime to knowingly provide false, incomplete, or misleading information for the purpose of defrauding a company. Penalties may include imprisonment, fines or a denial of benefits. I agree that no benefits will be effective until the date specified by Key Benefit Administrators. I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, the Veterans Administration, or any other organization, institution, insurance or reinsurance company, to disclose and release any information in its possession about the medical history, mental or physical condition or treatments of myself and/or my dependents to RGI, Inc., Key Benefit Administrators, Inc. or its designee. This authorization includes information about drug abuse, alcoholism or mental illness. I agree a photographic copy of this authorization shall be as valid as the original and that said authorization shall be valid for the maximum length of time permitted by law. I understand that I have the right to receive a copy of this authorization upon request. I authorize my employer to deduct from earnings the contributions (if any) required toward the benefits.

Employee (print name)**:** _____ **Employee Signature:** _____Date:_____

☐ DECLINING: Employee Signature: Sign, date, and return this form to your employer's HR department to implement the above enrollment/changes.

Waive/Decline Coverage

☐ Waive/Decline all coverage for **MYSELF** ☐ I am covered through another plan **OR** ☐ I do not wish to enroll. I understand I may not be able to enroll at a later date.
☐ Waive/Decline all coverage for my **SPOUSE** ☐ he/she is covered through another plan **OR** ☐ he/she does not wish to enroll. I understand my spouse may not be able to enroll at a later date.
☐ Waive/Decline all coverage for my **CHILDREN** ☐ they are covered through another plan **OR** ☐ they do not wish to enroll. I understand my children may not be able to enroll at a later date.

If I have waived benefits for myself and/or my dependent (including my spouse) because of other health benefits, I may in the future be able to enroll myself and/or my dependent in this plan, provided that I request enrollment within 30 days after my other benefits end because of involuntary loss of benefits (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 myself and my dependents, provided that I request enrollment within 30 days after the date of the event. I further understand that, other than these qualifying events, if this form is submitted after the enrollment period, I cannot enroll until the next annual enrollment period if applicable.

Employee (print name)**:** _____ **Employee Signature:** _____Date:_____

EMPLOYER SECTION

Original Hire Date:		Full Time Hire Date:	Benefit Effective Date:	Enrollment Location:
☐Hourly ☐Salaried ☐Commission	Annual Income:	Life Volume:	Occupation:	Number of Pay Periods Per Year:
☐ **Reinstatement** of coverage effective _____/_____/_____ due to: ☐ Return from lay-off ☐ Return from leave ☐ Rehired ☐ Other:				
☐ COBRA effective date _____/_____/_____ ; qualifying event date _____/_____/_____				