

WESTERN MUTUAL INSURANCE[®] COMPANY

P.O. Box 572450 ♦ Salt Lake City, Utah ♦ 84157-2450
(801) 263-8000 ♦ (800) 748-5340 ♦ Fax: (801) 263-1247

Arizona Uniform Questionnaire Appendix

EMPLOYEE INFORMATION (Please print using ink)

Employee Name _____ Em

Employee Address _____

Street City State Zip

Full-Time Hire Date _____ Job Title _____ Hours Worked Each Week _____

Home Phone _____ Work Phone _____ Cell Phone _____

Social Security # _____ Marital Status: Single Married Separated Divorced Widowed

Date of Birth _____ Sex: M F Height: _____ ft. _____ in. Weight: _____

Personal E-mail _____ (official use only)

Medical Coverage Requested:

Employee Only Employee and Spouse Employee and Child Employee and Children Family

DEPENDENT INFORMATION

Full Name* <small>(First, Middle Initial, Last)</small>	Relationship to Employee	Social Security # <small>(For Internal Use Only)</small>	Sex M/F	Birth Date	Height & Weight	Other Medical Insurance	Name of Other Medical Insurer
					__ ft. __ in. wt. __	<input type="checkbox"/> Yes <input type="checkbox"/> No	
					__ ft. __ in. wt. __	<input type="checkbox"/> Yes <input type="checkbox"/> No	
					__ ft. __ in. wt. __	<input type="checkbox"/> Yes <input type="checkbox"/> No	
					__ ft. __ in. wt. __	<input type="checkbox"/> Yes <input type="checkbox"/> No	
					__ ft. __ in. wt. __	<input type="checkbox"/> Yes <input type="checkbox"/> No	

* To be eligible for coverage, children must be the dependent age provided by statute, unmarried, and dependent upon you for 50% of their support. **ANY DEPENDENT NOT LISTED WILL NOT BE CONSIDERED FOR COVERAGE.**

PREEXISTING CONDITION EXCLUSION AND PORTABILITY CREDITS: If you have had health insurance coverage within the last 63 days, your Preexisting Condition waiting period limitation may be credited or waived upon receipt of your Certificate of Creditable Coverage from your prior health care plan. Benefits may not be payable for Preexisting Conditions for a period of twelve (12) months following your effective date of coverage (eighteen (18) months for a late enrollee). A Preexisting Condition is an illness or injury for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period prior to the enrollment date of coverage. **If a preexisting provision applies, each participant has the right to prove prior creditable coverage, including the right to secure a certificate from a prior plan of coverage.**

To obtain additional information regarding the preexisting condition exclusion, please contact the WMI Claims Department at (801) 263-8000 or (800) 748-5340. If you have had health coverage within the last sixty-three (63) days, **please enclose a copy of the Certificate of Creditable Coverage for each member to be covered** as proof of any prior coverage dating up to eighteen (18) months prior to the date of completion of this form and provide the following information:

Policyholder's Name _____ Name of Prior Insurance Carrier or Plan _____

Policy No. _____ Date Coverage Began _____ Date Coverage Ended _____

Submission of prior coverage information does not automatically waive the Preexisting Condition Waiting Period limitation. However, failure to provide prior coverage information will result in limited or excluded benefits for a 12-month period (18 months for late enrollees).

ADDENDUM TO EMPLOYEE AND FAMILY MEDICAL QUESTIONNAIRE

If any family member answered “Yes” to either question A14, “High/Low Blood Pressure”, or question A15, “High Cholesterol”, please complete the following:

Question #	Name of Individual	Last Reading	Date of Last Reading

AUTHORIZATION

I hereby apply to be enrolled with my listed dependents, if applicable, for coverage with Western Mutual Insurance Company (“WMI”). I understand no coverage will be in force until each person listed above is approved by WMI, that no benefits will be provided for any service which begins before the coverage is effective, and that benefits will not extend beyond the termination of my coverage. I understand that omissions or misrepresentations regarding information provided on this questionnaire could cause an otherwise covered service to be denied and/or void any coverage issued.

I authorize any physician, medical practitioner, hospital, clinic, any other provider of health care, or insurance company to disclose to WMI or its representatives all information and records of myself and my dependents relating to diagnosis, treatment, medical history, physical or mental condition, and evaluation thereof for which coverage by WMI is sought. I expressly waive on behalf of myself, my spouse and such dependents any legal action for such disclosure. This authorization shall remain valid for a period not to exceed twenty-four (24) months. A copy of this authorization shall have the same effect as the original.

I hereby declare that to the best of my knowledge and belief, the information given on this questionnaire, including the health information listed on the Employee and Family Medical Questionnaire, is correctly recorded, true and complete. If I subsequently become aware of information different from that provided in the Questionnaire, I agree to provide that information promptly to WMI. I understand that WMI retains the right to retroactively adjust premium rates and/or rescind coverage if necessary due to any incorrect information that is provided on the Questionnaire.

EMPLOYEE SIGNATURE _____ **DATE** _____

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or who knowingly presents false information during the application process is guilty of a crime and may be subject to civil fines and criminal penalties.

ENROLLMENT FORM - Print clearly in ink.

Name of Employee _____
 Last First Initial Social Security # Birth Date Home Phone

Mailing Address _____
 City State Zip Business Phone Date of Hire Hours Worked Weekly

Employer _____ Sex: Male Female Marital Status: Single Married Separated Divorced Widowed

Name of Spouse: _____
 Last First Initial Birth Date Social Security #

Names of Dependent Children	Sex	Birth Date	Social Security #

Type of Coverage: Employee Only Employee & Spouse Employee & Child Employee & Children Family

Medical: _____ Dental: * Yes No Vision: * Yes No Disability: * Yes No

Group Life Insurance: * Smoker Non-Smoker Amount: \$10,000 \$25,000 \$50,000 \$75,000 \$100,000 Other _____

Spouse: Smoker Non-Smoker Amount: \$10,000 \$25,000 \$50,000 \$75,000 \$100,000 Other _____

* Dental, Vision, Disability and Life insurance are subject to employer election and approval. Life insurance amounts in excess of \$25,000 require pre-approval.

Dependent Life: None One \$3,000 Unit Two \$3,000 Units (\$6,000 total)

Beneficiary: _____

Name Relationship Contingent

Spouse's: _____

Name Relationship Contingent

EMPLOYEE SIGNATURE _____ DATE _____

For Office Use Only	
Effective Date: _____	Termination Date: _____
Class Change Date: _____	VGL Amount: _____
Disability Income Amount: _____	
<input type="checkbox"/> Original Group	<input type="checkbox"/> Special Enrollee
<input type="checkbox"/> New Employee	<input type="checkbox"/> Late Enrollee

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information during the application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

WMI EE APP (11/07) -----

WAIVER OF GROUP COVERAGE

(MUST BE COMPLETED IF ANY COVERAGE IS DECLINED OR REFUSED BY ANY ELIGIBLE EMPLOYEE)

EMPLOYEE NAME _____ SOCIAL SECURITY # _____ EMPLOYER NAME _____

- | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p><input type="checkbox"/> I WAIVE ALL COVERAGE FOR MYSELF AND DEPENDENTS (IF ANY)</p> <p><input type="checkbox"/> I WAIVE HEALTH PLAN COVERAGE FOR MYSELF AND DEPENDENTS (IF ANY)</p> <p><input type="checkbox"/> I WAIVE HEALTH PLAN COVERAGE FOR MY SPOUSE ONLY</p> <p><input type="checkbox"/> I WAIVE HEALTH PLAN COVERAGE FOR MY CHILDREN ONLY</p> | <p>REASON FOR DECLINING COVERAGE (CHECK ONE):</p> <p><input type="checkbox"/> COVERED BY SPOUSE'S COVERAGE</p> <p><input type="checkbox"/> COVERED BY OTHER INSURANCE OR HMO</p> <p><input type="checkbox"/> COVERED BY CHAMPUS OR CHAMPVA</p> <p><input type="checkbox"/> OTHER (EXPLAIN) _____</p> |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

THIS IS TO ACKNOWLEDGE THAT THE AVAILABLE COVERAGES HAVE BEEN EXPLAINED TO ME BY MY EMPLOYER. I HAVE BEEN GIVEN THE OPPORTUNITY TO APPLY FOR THE AVAILABLE COVERAGES AND HAVE ELECTED NOT TO ENROLL MYSELF AND/OR MY DEPENDENTS, IF ANY.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if employer contributions towards your or your dependent's other coverage terminate), provided that you request enrollment within 31 days after your other coverage ends. 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 or your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. To request such special enrollment, please contact the Enrollment Department at (801) 263-8000 or (800) 748-5340.

EMPLOYEE SIGNATURE _____ DATE _____