

NOTICE TO EMPLOYEE: YOU HAVE THE RIGHT TO SUBMIT THIS CARD DIRECTLY TO WESTERN MUTUAL INSURANCE COMPANY OR, AT YOUR OPTION, TO YOUR EMPLOYER

WESTERN MUTUAL INSURANCE COMPANY P.O. BOX 572450; MURRAY, UT 84157-2450; (800) 748-5340, Local (801) 263-8000, Fax (801) 263-1247
HEALTH & VOLUNTARY GROUP LIFE INSURANCE ENROLLMENT FORM - TYPE OR PRINT CLEARLY, USE BLACK OR BLUE INK.

Employee Name	Last	First	Initial	Social Security #	Date of Birth	Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female
Home Address	City			State	Zip Code	Home Phone	
Name of Employer	Work Phone			Date of Hire	Monthly hours worked		
Name of Spouse	Last	First	Initial	Social Security #	Date of Birth	Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female
Names of Dependents	Last	First	Initial	Social Security #	Date of Birth	Sex	Relationship

Coverage Type: Employee Employee & Spouse Employee & Child Employee & Children Employee, Spouse & Children
Medical Plan: _____ **Vision:** YES NO
Dental: YES NO **Disability:** YES NO

Group Life Insurance: (Amounts in excess of \$25,000 require pre-approval)

Employee	Smoker	Non-Smoker	Amount:	\$10,000	\$25,000	\$50,000	\$75,000	\$100,000	Other
	Beneficiary:		(Name)	(Relationship)		(Contingent)			

Spouse	Smoker	Non-Smoker	Amount:	\$10,000	\$25,000	\$50,000	\$75,000	\$100,000	Other
	Beneficiary:		(Name)	(Relationship)		(Contingent)			

Dependent(s) None One Unit (\$3,000) Two Units (\$6,000)

For Office Use Only

Effective Date: _____

Termination Date: _____

Class Change Date: _____

VGL Amount: _____

Disability Income Amount: _____

Original Group Special Enrollee
 New Employee Late Enrollee

Employee Signature **Date**

Employee Name: _____	Social Security No.: _____
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PREEXISTING CONDITION EXCLUSION: Have you or any of your dependents had prior health insurance within the past 63 days? **YES** **NO**
 Benefits may not be payable for preexisting conditions for a period of twelve months (six months in New Mexico) following your effective date of coverage (eighteen 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. Let us know if you need assistance in obtaining a certificate of prior coverage. To obtain additional information regarding the preexisting condition exclusion, please contact Kellee Howell, Claims Department, (801) 263-8000 x116 or (800) 748-5340 x116.

Name of prior carrier: _____ **Carrier Phone #:** (_____) _____ **Policy #:** _____

Attach all certification forms verifying prior health plan coverage dating up to 18 months prior to this application.
 Certification form(s) are attached. Certification form(s) will be forwarded when received from prior benefit plans. This provision does not apply to me.

Statement of Health

1. In the past 10 years, have you or any of your dependents been treated for or had symptoms of immune system or blood disorder, cancer, tumor, diabetes, stroke, heart attack, heart disease or disorder?	YES	NO
2. Are you or any of your dependents currently pregnant or partially or totally disabled or handicapped?	YES	NO
3. In the past 5 years, have you or any of your dependents been treated for or had symptoms of any medical condition that may require surgical correction or hospitalization in the future?	YES	NO
4. In the past 10 years, have you or any of your dependents ever had, been treated for or been told you have abnormal blood pressure or other circulatory disorders, disorders of the nervous system, epilepsy, alcoholism, drug abuse, mental or emotional disorders, arthritis, bone, joint or back disorders, hernia, disorders of the stomach, intestines or rectum, liver disorders, lung or respiratory disorder, eye or ear disorder, disorder of the urinary tract, kidneys or reproductive system?	YES	NO
5. In the past 5 years have you or any of your dependents had any mental or physical disorders, examination, hospitalization, treatment, medical advice or surgery not mentioned above?	YES	NO
6. Have you or any of your dependents taken prescription medication within the past 24 months?	YES	NO

LIST FULL DETAILS TO ANY QUESTIONS YOU HAVE ANSWERED "YES."

Person	Nature of Ailment or Illness, prescription etc.	Duration & Dates of treatment	Date of Recovery	Name & Address of each Physician, Hospital, etc.

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, the information given on this application is correctly recorded, true and complete. I understand that WMI retains the right to retroactively adjust premium rates and/or rescind coverage if necessary due to any incorrect information provided on this application.

Employee Signature **Date**

WAIVER OF GROUP COVERAGE

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

EMPLOYEE NAME _____

SOCIAL SECURITY # _____

EMPLOYER NAME _____

I WAIVE TOTAL COVERAGE FOR MYSELF
(AND DEPENDENTS, IF ANY)

I WAIVE HEALTH PLAN COVERAGE FOR MYSELF
(AND DEPENDENTS, IF ANY)

I WAIVE HEALTH PLAN COVERAGE FOR MY SPOUSE ONLY

I WAIVE HEALTH PLAN COVERAGE FOR MY CHILDREN ONLY

REASON FOR DECLINING COVERAGE (CHECK ONE):

COVERED BY SPOUSE'S COVERAGE

COVERED BY CHAMPUS OR CHAMPVA

COVERED BY HMO

OTHER (EXPLAIN) _____

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 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 (60 days in Idaho) after the marriage, birth, adoption or placement for adoption. To request such special enrollment, please contact Kay Harrison, Enrollment Department, (801) 263-8000 x104 or (800) 748-5340 x104.

EMPLOYEE SIGNATURE

DATE