



EMPLOYEE MEDICAL EVIDENCE OF INSURABILITY & APPLICATION
 Application to American Alternative Insurance Corp. Princeton, NJ
 May be Photocopied or Duplicated for use. Please complete in ink and initial any alterations.



SECTION 1 – APPLICANT INFORMATION

FULL NAME OF EMPLOYEE			MARITAL STATUS		ADM. Use Only	
RESIDENCE ADDRESS		CITY	STATE	ZIP		CASE NO.
TELEPHONE NUMBER (include area code)		Best time to contact (if additional information is required by Insurance Company)				EMPLOYEE NO.
DATE BEGAN FULL TIME (mm/dd/yy)		SOCIAL SECURITY NUMBER				CLASS
EMPLOYED BY		EMPLOYERS' PHONE (include area code)	AVG. NO. HOURS WORKED WEEKLY	MONTHLY EARNINGS		EFFECTIVE DATE
EMPLOYER'S LOCATION – STREET ADDRESS		CITY	STATE	ZIP		OCC YES <input type="checkbox"/> NO <input type="checkbox"/>
OCCUPATION AND DUTIES		LIFE INSURANCE BENEFICIARY AND RELATIONSHIP				UWF 48 YES <input type="checkbox"/> NO <input type="checkbox"/> DATE _____
<input type="checkbox"/> I AM <input type="checkbox"/> I AM NOT AN OWNER, PARTNER OR CORPORATE OFFICER OF THE ABOVE EMPLOYER						UWF 40 YES <input type="checkbox"/> NO <input type="checkbox"/>
I Am Applying for (check one): <input type="checkbox"/> SELF ONLY <input type="checkbox"/> SELF AND SPOUSE <input type="checkbox"/> SELF AND CHILD(REN) <input type="checkbox"/> SELF, SPOUSE, & CHILD(REN)						HEALTH YES <input type="checkbox"/> NO <input type="checkbox"/> LIFE YES <input type="checkbox"/> NO <input type="checkbox"/>
I Am Applying for (check all that apply): <input type="checkbox"/> HEALTH INSURANCE <input type="checkbox"/> LIFE INSURANCE						

If you have dependents (spouse and/or children) and have chosen not to include any dependents in this coverage, please complete the following:
 I AM NOT APPLYING FOR DEPENDENT COVERAGE FOR SPOUSE CHILDREN BECAUSE (check one):

Covered by another group/individual health plan. Other (explain) _____

I understand that, if I have dependents and do not make application at this time, I may be forfeiting certain rights as described on the reverse under Applicant Statement. I understand that I have the right to apply for dependent coverage at this time. I am voluntarily declining dependent coverage and have not been induced or pressured by anyone to decline coverage.

PARTICIPANT INFORMATION							ADM. USE ONLY					
Participant Information Complete for each person to be insured. (use additional sheet if necessary)	NAMES OF PARTICIPANTS	RELATIONSHIP	SEX	HEIGHT	WEIGHT	DATE OF BIRTH	MUW	MHX	LAT	D&R	PXT	
	1.	Employee Name	Self									
	2.											
	3.											
	4.											
	5.											
	6.											

SECTION 2 – PRIOR INSURANCE COVERAGE CREDIT

Have you or your dependents been covered under any health insurance plan within the last 90 days?..... YES NO
 If Yes, to qualify for prior coverage credit, please provide the following information on all coverage in force in the past 12 months – Please note that most of this information can be obtained from your current Insurance Identification Card:

Name of Insurance Company _____ Ins. Co. Phone Number () _____

Effective date of Prior Coverage* _____ Termination Date _____

Reason for Coverage Termination _____

Type of Coverage (i.e., employer sponsored or individual) _____ Policy/Cert. Number _____

Coverage was for (check all that apply): Self Spouse Children

**We need confirmation of your coverage with your prior carrier. Please provide us with a copy of the Certificate of Creditable coverage provided by the carrier.*

SECTION 3 – MEDICAL INFORMATION Please give details to any “Yes” answer below.

1. Has anyone applying within the last 10 years been diagnosed as having or been treated for human immunodeficiency virus (HIV) infection or any other acquired immune deficiency syndrome (AIDS) or AIDS related complex (ARC), significant weight loss, chronic fatigue or diarrhea, night sweats or enlarged glands? YES NO
2. Are you or any dependent (whether applying for coverage or not) currently pregnant, anticipating surgery or is anyone applying for coverage disabled, restricted or unable to perform the normal activities of daily living and self care? YES NO
3. During the past 5 years, has anyone applying for coverage visited a doctor, had a medical consultation, had surgery, or been hospitalized? YES NO
4. Is anyone currently taking medication? YES NO
5. Have you or anyone applying for coverage in the past 10 years had a diagnosis of or consultation, treatment or medication for:

	YES	NO		YES	NO
Brain or Nervous System	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid or Pituitary Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Nervous, Mental or Emotional Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes or Sugar in Urine	<input type="checkbox"/>	<input type="checkbox"/>
Drug or Alcohol Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Disease of the Muscles	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy or Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>	Bone or Joint Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis, Rheumatism, Bursitis	<input type="checkbox"/>	<input type="checkbox"/>
Heart or Circulatory System	<input type="checkbox"/>	<input type="checkbox"/>	Disorders of Back or Spine	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain or Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Lungs or Respiratory System	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disorder or Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema, Tuberculosis, Chronic Obstructive Pulmonary Disease or Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Digestive or Gastrointestinal Tract	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis or Cystic Fibrosis	<input type="checkbox"/>	<input type="checkbox"/>
Cirrhosis or Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Skin or Collagen Disease	<input type="checkbox"/>	<input type="checkbox"/>
Liver, Pancreas or Kidney	<input type="checkbox"/>	<input type="checkbox"/>	Cancer, Leukemia or Hodgkin's Disease	<input type="checkbox"/>	<input type="checkbox"/>
Rectum, Prostate or Hernia	<input type="checkbox"/>	<input type="checkbox"/>	Lymphatic Vessels or Glands	<input type="checkbox"/>	<input type="checkbox"/>
Genitourinary System	<input type="checkbox"/>	<input type="checkbox"/>	Any Physical Deformity or Defect	<input type="checkbox"/>	<input type="checkbox"/>
Breast or Reproductive Organs	<input type="checkbox"/>	<input type="checkbox"/>			
Endocrine or Adrenal Disorder	<input type="checkbox"/>	<input type="checkbox"/>			
6. Is there any existing medical condition or problem, including any undiagnosed symptoms that have not otherwise been indicated on this application? YES NO

Use this space to give details to any “YES” answer to questions 1 through 6. Use a separate sheet if additional space is needed; sign & attach additional pages. If taking medication for high blood pressure, please include your last 3 blood pressure readings.

Person	Medical Condition or Specific Reason for Treatment	Dates of Treatment	Medications & Dosages	Recovery Status	Please list any treatment, surgery or anticipated surgery for this condition.

SECTION 4 – APPLICANT STATEMENT AND SIGNATURE

I hereby apply for insurance to which I am now or may become entitled under the provisions of the Master Policy issued by the Insurance Company. I authorize my employer to pay premiums and to deduct any required premium contribution from my earnings. I understand that my employer is being authorized to pay premium, is my agent and not the agent of the Insurance Company, and that my insurance may be terminated if premiums are not paid by my employer as required.

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be found guilty of insurance fraud in a court of law. I understand that my coverage, if approved, and that of my eligible dependents, will be subject to the pre-existing condition and replacement of coverage provisions specified in the Master Policy. I understand that, subject to the replacement of coverage provisions of the Master Policy, I may not be eligible for coverage if I am currently totally disabled.

If I choose not to apply for dependent coverage and my dependents do not currently have other qualifying coverage, I understand that my dependents' right to enroll in the future may be restricted: 1) For medical insurance in all states but Texas, either their effective date of coverage will be delayed or their Pre-Existing Condition Limitation Period will be extended to eighteen (18) months; 2) For medical insurance in Texas, their Pre-Existing Condition Limitation Period will be extended to eighteen (18) months; and 3) For life insurance in all states, satisfactory evidence of their insurability will be required at my expense. Refer to the Late Applicant Eligibility, Effective Dates and Pre-Existing Conditions Limitations provisions set forth in the Master Policy. As a result, I also waive all claims under the Master Policy to such forfeited benefits for my dependents.

PERSONAL INFORMATION NOTICE

As required by law, this notice is intended to inform you that 1) Personal information may be collected from persons other than the individual applying for coverage; 2) Such information as well as other personal or privileged information collected by the Insurance Company or its legal representative may be in certain instances, as prescribed by law, disclosed to third parties without your prior authorization; 3) You have the right to access and correct the collected information; 4) Your right to access does not include any information which relates to and is collected in connection with, or in reasonable anticipation of, a claim or civil or criminal proceeding; 5) We will provide a more detailed notice of insurance information practices upon request.

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize the disclosure of all nonpublic personal information and individually identifiable protected health information for me (and my dependent(s), if requesting dependent coverage), including but not limited to employment status, other insurance coverage, diagnosis, prognosis, medical treatment or care and physical or mental conditions (including alcohol or drug dependency), by any physician, medical practitioner, hospital, other medical related facility, insurance company, employer or benefit plan having such information, to the Insurance Company or its legal representative, agent or vendor, for the purpose of approving enrollment and processing claims. I acknowledge and agree that this authorization shall be valid for two (2) years; that I may revoke it in writing at any time; that I may request a copy of this authorization; that enrollment, but not the processing of claims, is conditioned on my signing this authorization; that this authorization will be used as its own document, separate from the application; that a photocopy of this authorization shall be as valid as the original; and that I have authority to act as the personal representative of my dependent(s) (if requesting dependent coverage).

Signature of Employee X _____ Date _____