LIBERTY UNION LIFE ASSURANCE COMPANY
560 KIRTS BLVD SUITE 125
TROY MI 48084

☐ **New Employee Enrollment** ☐ **Open Enrollment**
☐ **Change for Existing Employee (Complete Change Request Section)**
PLAN/GROUP _____

EMPLOYEE APPLICATION

MUST BE COMPLETED BY THE EMPLOYEE, SPOUSE OR DEPENDENT CHILDREN AGE 18 OR OLDER
(Not to be completed by the Agent, Employer or any other person not named as an applicant on this form)

EMPLOYER INFORMATION (TO BE COMPLETED IN **ALL** SITUATIONS)

EMPLOYER NAME	EMPLOYER ADDRESS	CITY STATE ZIP
EMPLOYER LOCATION	OCCUPATION	
DATE OF HIRE (Full Time)	AVERAGE HOURS WORKED PER WEEK	BASIC SALARY $_____ PER _____

EMPLOYEE INFORMATION (TO BE COMPLETED IN **ALL** SITUATIONS)

LAST NAME	FIRST NAME	MIDDLE INITIAL	☐ SINGLE ☐ DIVORCED ☐ MARRIED ☐ LEGALLY SEPARATED
ADDRESS	CITY	STATE ZIP	

HOME PHONE ( )	CELL PHONE ( )	EMAIL ADDRESS

DATE OF BIRTH (M/D/Y)	SEX (M/F)	HEIGHT	WEIGHT	SOCIAL SECURITY NUMBER

BENEFICIARY	RELATIONSHIP

DEPENDENT INFORMATION (TO BE COMPLETED ONLY IF DEPENDENTS ARE TO BE COVERED)

LAST NAME FIRST NAME INITIAL	RELATIONSHIP	SEX (M/F)	DATE OF BIRTH	HEIGHT	WEIGHT	SOCIAL SECURITY NUMBER
	SPOUSE					

OTHER INSURANCE (TO BE COMPLETED FOR ALL COVERED FAMILY MEMBERS)

1. Are you or any covered dependent currently enrolled in any other group coverage (not being replaced by this coverage) including Medicare or Medicaid? ☐YES ☐NO
   If YES:
   Person(s) Covered _____ Type: ☐ Medical ☐ Dental ☐ Pediatric Dental
   Plan or Carrier Name _____ ID# _____

COVERAGE INFORMATION (TO BE COMPLETED IN ALL SITUATIONS)

☐ LIFE INSURANCE: ☐ MINIMUM AMOUNT OR ☐ $_____ ☐ SUPPLEMENTAL LIFE $_____
☐ DEPENDENT LIFE: # OF UNITS_____

					WAIVER
☐ MEDICAL	☐ Employee Only	☐ Employee & Spouse	☐ Employee & Children	☐ Family	☐ NONE
☐ PRESCRIPTION	☐ Employee Only	☐ Employee & Spouse	☐ Employee & Children	☐ Family	☐ NONE
☐ DENTAL	☐ Employee Only	☐ Employee & Spouse	☐ Employee & Children	☐ Family	☐ NONE

CHANGE REQUEST (please select appropriate change and complete the new information on this application)

☐ BENEFICIARY CHANGE ☐ NEW EMPLOYEE ADDRESS ☐ EMPLOYEE NAME CHANGE (previous name) _____
☐ ADD DEPENDENTS ☐ CHANGE IN LIFE AMOUNT ☐ REMOVE DEPENDENTS (list names) _____
☐ DATE MARRIED _____ ☐ DATE DIVORCED _____
☐ OTHER (explain) _____ DATE OF CHANGE: _____/_____/_____

PRIOR COVERAGE

Complete to determine appropriate credit. Certificate of creditable coverage from your prior carrier should be attached.
Prior Coverage Start Date _____ End Date _____ Types of Coverage _____
Covered Individuals _____
Prior Plan or Carrier Name _____**Reason for ending prior coverage** _____

I (the Employee) completed the following information as it pertains to me and that of my dependents. If I am not applying for dependent coverage, then the answers relate to me only. If I am applying for dependent coverage, I verify the signatures below are that of my spouse and/or dependent children age 18 or older. **NOTE:** ANY PERSON WHO SUBMITS AN APPLICATION, FILES A CLAIM WITH INTENT TO DEFRAUD, OR HELPS COMMIT FRAUD IS GUILTY OF A CRIME THAT MAY BE PUNISHABLE BY LAW.

	YES	NO		YES	NO
TO BE COMPLETED BY APPLICANT(S) ONLY			**j: Alcohol, chemical or substance abuse?**	☐	☐
1: Are you currently actively employed on a full-time basis?	☐	☐	**k: Liver disorder, cirrhosis, pancreatitis, hepatitis?**	☐	☐
			l: Stroke, paralysis, epilepsy?	☐	☐
			m: Sleep disorder/sleep apnea?	☐	☐
2: Are you or any dependent, whether or not named on this application, now pregnant;	☐	☐	**n: Cancer, tumor?**	☐	☐
			o: Birth defects?	☐	☐
Been treated/tested for infertility, premature delivery, miscarriage, c-section or any other complications of pregnancy?	☐	☐	**p: Neurological condition or multiple sclerosis?**	☐	☐
			q: Systemic lupus?	☐	☐
a: Do you anticipate adding any dependent(s) to your coverage within the next 12 months?	☐	☐	**r: Deviated septum or breathing disorder?**	☐	☐
3: Are you or any dependent now disabled or confined to a Medical Facility?	☐	☐	**s: Glaucoma, cataracts, or diseases of the eye?**	☐	☐
			t: Otitis media, ear or hearing disorder?	☐	☐
			u: Skin disease or skin disorder?	☐	☐
4: Have you or any dependent incurred medical expenses more than $5000 in the previous 24 months?	☐	☐	**6: Have you or any dependent smoked cigarettes in the last 12 months?**	☐	☐
5 Within the past 5 years, have you or any dependent had any indication, diagnosis, consultation, treatment, taken any medication or received counseling for:			**7: Are you or any dependent presently ill, taking medication, receiving treatment, or been advised of a condition that will require treatment or surgery in the next 12 months?**	☐	☐
a: Stomach, gallbladder, Crohn's disease, intestinal or colon disorder?	☐	☐	**8: Have you or any dependent had medical care or treatment by a medical professional for AIDS or any AIDS related complex, for any immune system disorder or tested positive for HIV?**	☐	☐
b: Bladder, kidney disorder, protein or blood in urine?	☐	☐			
c: Male/female organ disorders infertility, sexually transmitted disease?	☐	☐			
d: Heart, circulatory disorder, varicose veins, high blood pressure?	☐	☐			
e: Emphysema, asthma or other disease of the lungs or respiratory system?	☐	☐	**9: Have you or any dependent, for any reason NOT stated above, during the past 5 years:**		
f: Thyroid disorder or lymph node enlargement?	☐	☐	**a: Been hospitalized or advised to be hospitalized?**	☐	☐
g: Diabetes, blood or blood sugar disorder?	☐	☐	**b: Had surgery or advised to have surgery?**	☐	☐
h: Nervous, mental or emotional disorder?	☐	☐	**c: Had any injury, illness, medical attention, medical advice or treatment?**	☐	☐
i: Arthritis, back or joint disorder, received chiropractic care?	☐	☐			

DETAILS TO "YES" ANSWERS (***If more space is needed attach an additional sheet of paper, dated and signed***)

Question Number	NAME	CONDITION DIAGNOSIS	TREATMENT, MEDICATION, DOSAGE & RECOVERY STATUS	DATES TREATED	PROVIDE NAME, ADDRESS & PHONE OF ALL PHYSICIANS FOR YOURSELF AND FAMILY - USE SEPARATE SHEET, IF NEEDED.

APPLICANT VERIFICATION OF ENROLLMENT STATEMENTS

I state the above answers are true and complete. I understand that intentional failure to disclose information that is reasonably known by me or my dependents will result in a rescission (termination) of coverage. The Administrator has the right to rescind due to intentional material misrepresentation during enrollment.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize any medical professional, hospital, clinic, pharmacy, pharmacy benefits manager or any entities covered under the HIPAA Privacy Rule and their agents and employees to disclose my personal health information to the Administrator or their authorized representative. This includes information about the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection, sexually transmitted diseases, mental illness, and the use of alcohol, drugs, and tobacco. This is also valid for my dependents. I understand this authorization will be used by the TPA/Administrator for the purpose of underwriting my application for coverage, eligibility, rating and enrollment decisions regarding the coverage I am applying for. I understand that any authorized representative or I may receive a copy of this authorization upon request. This authorization is valid from the date signed and until the date any approved coverage is terminated unless revoked by me in writing to the Administrator which I may do at any time. Any revocation will not affect any prior use of this authorization by the Administrator. I understand information obtained with my authorization may be re-disclosed by the Administrator as permitted or required by Law and no longer protected by the federal privacy law. I have had the opportunity to read and consider the contents of this authorization and confirm that the contents are consistent with my direction.

EMPLOYEE SIGNATURE _____ DATE _____

SPOUSE SIGNATURE _____ DATE _____

DEPENDENT SIGNATURE (AGE 18 OR OVER) _____ DATE _____

DEPENDENT SIGNATURE (AGE 18 OR OVER) _____ DATE _____