MID AMERICA ASSOCIATES, INC.
560 KIRTS BLVD STE 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** _____

	YES	NO		YES	NO
TO BE COMPLETED BY APPLICANT(S) ONLY **1: Are you currently actively employed on a full-time basis?**	☐	☐	**j: Been evaluated for alcoholism or chemical dependence or joined any organization for alcoholism or chemical dependency; or used illegal drugs or been advised by a health care professional to reduce the use of alcohol or substance abuse?** **k: Liver/pancreas disorder, cirrhosis, 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; **Been treated or tested for infertility, premature delivery, miscarriage, c-section or any other complications of pregnancy?** **a: Do you anticipate adding any dependent(s) to your coverage within the next 12 months?**	☐ ☐ ☐	☐ ☐ ☐	**n: Cancer, tumor?** **o: Birth defects?** **p: Neurological condition or multiple sclerosis?** **q: Systemic lupus?** **r: Deviated septum or breathing disorder?**	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐
3: Are you or any dependent now disabled, confined to a medical facility or unable to perform normal work or age related activities?	☐	☐	**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 of more than $5000 in the previous 24 months?	☐	☐	**6: Have you or any dependent smoked cigarettes in the last 12 months?**	☐	☐
5 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, ulcer or colon disorder? **b: Bladder, kidney disorder, protein or blood in urine?** **c: Male/female organ including infertility, sexually transmitted disease, prostate or menstrual disorders?** **d: Heart disease, chest pain, high blood pressure, circulatory disorder or varicose veins?**	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	**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?**	☐	☐
e: Emphysema, asthma or other disease of the lungs or respiratory system, sinus or nasal disorder, shortness of breath?	☐	☐	**9: Have you or any dependent, for any reason NOT stated above, during the past 5 years:**		
f: Thyroid, adrenal disorder or lymph node enlargement? **g: Diabetes, blood or blood sugar disorder?** **h: Attention deficit disorder, eating disorder, nervous, mental or emotional disorder?** **i: Musculoskeletal, connective tissue disorder, fibromyalgia, chronic fatigue syndrome, arthritis, back or joint pain, chiropractic care?**	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐	**a: Been hospitalized or advised to be hospitalized?** **b: Had surgery or advised to have surgery?** **c: Had any injury, illness, medical attention, medical advice or treatment?**	☐ ☐ ☐	☐ ☐ ☐

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.

I (the Employee) completed all information on this application 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.**

APPLICANT VERIFICATION OF ENROLLMENT STATEMENTS

I state that all 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 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 _____