EMPLOYEE ELIGIBILITY STATEMENT

CONFIDENTIAL

EMPLOYER NAME ______________________ VEBA ID NO. (FEIN #) ______________________

THE PLAN IS SELF INSURED. THE GROUP HEALTH BENEFITS PROVIDED BY THE PLAN ARE NOT AN INSURANCE PRODUCT, AND THE PLAN IS NOT APPROVED BY ANY STATE INSURANCE REGULATOR. ANY REPRESENTATION TO THE CONTRARY IS FALSE.

Your employer offers group health benefits through a self insured plan (the "Plan") that is governed by the Employee Retirement Income Security Act of 1974, as amended, and is a Voluntary Employees' Beneficiary Association Trust under the Internal Revenue Code of 1986, as amended, (the "Trust"). Your employer's contributions and your contributions made for funding the costs of the group health benefits provided under the Plan to you and, if applicable, your spouse and/or dependents will be deposited with the Trust and managed by the Trustee.

The Trust requires your detailed medical history to determine the appropriate amount of contributions that your employer and you must make to the Trust. Please complete this enrollment information statement carefully and honestly. Only the EMPLOYEE should answer these questions for all covered members under the employee coverage. Please write legibly in ink.

FALSE, INCOMPLETE OR MISLEADING INFORMATION ON THIS ELIGIBILITY STATEMENT COULD LEAD TO RESCISSION OF YOUR PARTICIPATION IN THE PLAN AND/OR DENIAL OF CLAIMS MADE BY YOU OR , IF APPLICABLE, YOUR SPOUSE AND/OR DEPENDENTS. (1)

If you prefer not to discuss or disclose any preexisting medical conditions of you or, if applicable, your spouse and/or dependents, your employer can provide you information on how you may be able to obtain individual health insurance coverage through the federal or, if applicable, a state, health insurance exchange. However, you would not be able to participate in the Plan.

EMPLOYER INFORMATION

COMPANY NAME | LOCATION (state, zip)

PLAN CHOICE (if available) DEDUCTIBLE | PHYSICIAN/HOSPITAL NETWORK | PROPOSED EFFECTIVE DATE

EMPLOYEE INFORMATION

LEGAL FIRST NAME | MIDDLE INITIAL | LEGAL LAST NAME

ADDRESS | CITY | STATE | ZIP

SEX: O MALE O FEMALE | SOCIAL SECURITY NUMBER | BIRTH DATE (MM/DD/YYYY) | MARITAL STATUS: O SINGLE O MARRIED

WORK PHONE | HOME PHONE | DATE OF HIRE | HOURS WORKED /WK | EMPLOYEE EMAIL

I WANT TO APPLY FOR COVERAGE UNDER THE PLAN

COVERAGE APPLYING FOR (check only one)

- O Employee Only
- O Employee and Spouse/ Domestic Partner *
- O Employee and Child(ren)
- O Employee, Spouse/Domestic Partner and Child(ren)

REASON FOR ENROLLMENT (check only one)

- O New Group Plan
- O New Hire
- O Plan Change
- O Open/Late Enrollment
- O Special Enrollee (include Special Enrollee Form AD41)

* If employer has designated eligibility for domestic partners, coverage may be included for a domestic partner as an eligible dependent.

PRINT NAME AND SIGNATURE ______________________

DATE ______________________

I DECLINE COVERAGE UNDER THE PLAN

- O Declining all group coverage. I acknowledge that I have been given the opportunity to apply for group coverage available to me and my dependents through my employer.
- O Medical coverage declined for:
  - O Employee O Spouse/Domestic Partner O Child(ren)

I WISH TO DECLINE FOR THE FOLLOWING REASON (check only one)

- O Covered by spouse/domestic partner's group health plan.
- O Government Plan:
  - O Medicare O Medicaid O State plan
- O Individual Medical Plan
- O Not Affordable
- O COBRA/State Continuation **
- O Other

** If you are declining coverage due to COBRA/State Continuation, you MUST complete the entire Eligibility Statement.

PRINT NAME AND SIGNATURE ______________________

DATE ______________________

(1) (a) the Plan provides minimum essential coverage under ACA such that employee will satisfy the ACA individual mandate requirement, (b) the health/medical information can only be used for underwriting/rating purposes but not to deny participation in the plan or to result in pre-existing exclusions from coverage, and (c) your employer will not have access to your health/medical information you provide on this Eligibility Statement.

DEPENDENT INFORMATION

List the dependents to be covered. NOTE: If you are waiving coverage for your dependents, please complete the **COVERAGE INFORMATION** section on the first page.

SPOUSE/DOMESTIC PARTNER LEGAL FIRST NAME	LEGAL LAST NAME	BIRTH DATE (MM/DD/YYYY)	SOCIAL SECURITY NUMBER	SEX
				◯ M ◯ F
CHILD LEGAL FIRST NAME	**LEGAL LAST NAME**	**BIRTH DATE (MM/DD/YYYY)**	**SOCIAL SECURITY NUMBER**	**SEX**
				◯ M ◯ F
CHILD LEGAL FIRST NAME	**LEGAL LAST NAME**	**BIRTH DATE (MM/DD/YYYY)**	**SOCIAL SECURITY NUMBER**	**SEX**
				◯ M ◯ F
CHILD LEGAL FIRST NAME	**LEGAL LAST NAME**	**BIRTH DATE (MM/DD/YYYY)**	**SOCIAL SECURITY NUMBER**	**SEX**
				◯ M ◯ F

PRIOR COVERAGE

Did you or any dependent(s) enrolling on this form have prior major medical coverage within the last 12 months? ◯ YES ◯ NO

If Yes, complete this section:

PRIOR CARRIER NAME: ______________________ START DATE: / / END DATE: / /

WHO WAS COVERED?

◯ EMPLOYEE ◯ SPOUSE/DOMESTIC PARTNER ◯ CHILDREN

OTHER COVERAGE

Do you or any dependent(s) enrolling on this form have existing major medical coverage that will be in effect on the day this coverage begins? *If Yes, complete this section:* ◯ YES ◯ NO

OTHER CARRIER NAME: ______________________ START DATE: / /

If Medicare, check type of coverage: PART A EFFECTIVE DATE: ________ PART B EFFECTIVE DATE: ________ PART D EFFECTIVE DATE: ________

WHO WAS COVERED?

◯ EMPLOYEE ◯ SPOUSE/DOMESTIC PARTNER ◯ CHILDREN

MEDICAL INFORMATION

The following health questions apply to ALL members (subscribers, dependents, spouses, domestic partners) joining the coverage. Please check all that apply. If you answer yes to any of the following questions (1 to 5) we as that you complete a further explanation.

1

Within the last 5 years have you or any dependent applying for coverage received or been scheduled to have treatment and/ or medication(s) for, consulted a physician or other medical professional, or had any test performed for any disorders of conditions of the following?

	YES	NO
A: Autoimmune and/or connective tissue disorder, Lupus or other Systemic disorder	◯	◯
B: Blood disorder (including Anemia and Hemophilia)	◯	◯
C: Cancer or tumor	◯	◯
D: Congenital disorder	◯	◯
E: Digestive disorder (including acid reflux): includes colon, intestinal, stomach esophageal	◯	◯
F: Growth disorder or hormone disorder (including thyroid)	◯	◯
G: Heart or circulatory (including high blood pressure or cholesterol)	◯	◯
H: HIV positive of AIDS	◯	◯
I: Liver or Pancreas	◯	◯
J: Muscle or joint disorders	◯	◯
K: Neurological (Multiple Sclerosis, Paralysis, Palsy, Seizures, Stroke, other)	◯	◯
L: Reproductive disorder	◯	◯
M: Pregnancy - Anyone pregnant OR expecting (please indicate natural or cesarean section anticipated)	◯	◯
M: (a) Expecting twins or more	◯	◯
N: Rheumatoid Arthritis	◯	◯
O: Kidney (including kidney stones)	◯	◯
P: Respiratory (including asthma or allergies)	◯	◯
Q: Chron's disease	◯	◯
R: Any planned surgeries, MRI's, CT-Scans, Advanced Imaging	◯	◯
S: Any medical condition(s), doctor visits, surgeries, or prescription(s) not listed above in the last 5 years	◯	◯

2 EMPLOYEE'S HEIGHT ____________ WEIGHT ____________

SPOUSE/DOMESTIC PARTNER (if applicable) HEIGHT ____________ WEIGHT ____________

	YES	NO
3 **Have you or your spouse/domestic partners used any tobacco products in the past 12 months?**		
EMPLOYEE:	○	○
SPOUSE/DOMESTIC PARTNER:	○	○
4 **Have you or any dependent(s) applying for coverage been hospitalized, had surgery, or had more than $5,000 in medical expenses in the last 12 months?**	○	○
5 **Have you or any dependent(s) applying for coverage been advised that hospitalization or surgery will be necessary in the next 12 months**	○	○

MEDICATIONS

Please list **all medications** you or your family members are currently taking or have taken in the last 5 years. If you **DO NOT** want to disclose pre-existing medical conditions, you don't have to, and the employer will share health insurance exchange options. You will not be able to participate in this plan.

NAME	MEDICATION \ LAST TREATED	DOSAGE	FREQUENCY daily/weekly/monthly/annually
1:		mg/other	
2:		mg/other	
3:		mg/other	
4:		mg/other	
5:		mg/other	

As part of our routine underwriting procedure, you may receive a telephone call from the Trustee or the Trust's third-party administrator. Please make sure the caller has your PIN and the last four digits of your social security number for privacy and security purposes. Never divulge your complete social security number. Please provide detailed medical information on this form to reduce the need for a phone interview. Your answers will be strictly kept confidential, subject to applicable privacy laws and regulations.

REQUIRED EXPLANATION OF MEDICAL INFORMATION RESPONSES

Please provide details for **each YES answer.** If more space is needed, attach a separate sheet, sign and date it.

QUESTION #: ____________ LETTER: ____________

PERSON WITH CONDITION: ____________ EXACT DIAGNOSIS: ____________

DATE DIAGNOSED: ____________ DATE LAST TREATED: ____________

LIST ALL MEDICATION(S) PRESCRIBED FOR THIS CONDITION:

NAME	DOSAGE	FREQUENCY daily/weekly/monthly/annually	CURRENTLY TAKING? YES	NO
1:	mg/other		○	○
2:	mg/other		○	○
3:	mg/other		○	○

LIST ALL TREATMENT RECEIVED FOR THIS CONDITION:

LIST ALL TESTS PERFORMED FOR THIS CONDITION:

RESULTS, READINGS AND DATES:

ANY RELAPSES OR FLARE UPS? YES ○ NO ○ DATES (if applicable): ____________

ARE FUTURE TESTS, TREATMENT, OR SURGERIES RECOMMENDED? YES ○ NO ○

IF YES, WHAT HAS BEEN RECOMMENDED? ____________

ANTICIPATED DATE(S): ____________ PROGNOSIS: ____________

AGREEMENT TO ENROLL FOR COVERAGE

Unless waived on Page 1, I request coverage under my employer's plan as it is now or as it may be amended in the future. I authorize my employer to make deductions from my earnings for my share of the cost, if any, for the benefits to which I may become entitled. I represent that all statements and answers made in this Employee Eligibility State mentorany medical questionnaires are complete and true, and I understand that answers will be the basis of any coverage issued.

ALSO UNDERSTAND THAT ALL STATEMENTS AND ANSWERS MADE WILL BE VALID FOR 60 DAYS FROM THE DATE SIGNED. I agree to provide an updated statement if the effective date is pass the 60 days of the prior statement made by me. I agree to notify the program, my employer and any agent representing my company benefit plans of any changes in my health in above reference questions prior to the effective date of coverage.

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION
Instructions: please read this authorization form carefully before signing. Your request to enroll for coverage cannot be processed without your signature. You have the right to receive a copy of this form following your signature.

I. Protected Health Information
We are committed to the privacy of your PHI/Personal Information and has required all business associates and vendor so agree in writing to those same protections. Despite these efforts we are required by law to advise you that your Information may at some point fall outside of these protections, be re-disclosed and would no longer be protected.

This authorization encompasses information that is considered to be Protected Health Information and/or Personal Information. Protected Health Information (PHI) includes individually identifiable health information that is created or received by your provider, health plan or insurer, data clearing house, a health authority, employer, school or university.

PHI/Personal Information relates to the past, present, or future condition of your physical or mental health, healthcare provided to you, or payment for the healthcare
provided to you. PHI/Personal Information does not include summary health information or information that has been de-identified according to the standards for de-identification provided for in the Health Insurance Portability Act Privacy Rule.

By signing this form, I authorize certain entities identified below to use or disclose my protected health information. Protected health information includes, but is not limited to, hospital records, physician records, lab results, mental health records and alcohol and/or drug abuse records. Protected health information may be obtained, maintained, or transmitted in any form or medium, including written, oral, or electronic.

II. Purpose of the Authorization Form
By signing this form, I authorize the use and disclosure of protected health information for the purposes of: determining eligibility for enrollment or benefits under a health plan; determining eligibility and/or risk-rating of stop-loss insurance coverage for my employer, or to allow the plan's designee to conduct utilization review and quality improvement activities ("Purpose").

III. Entities Authorized to Use and Disclose My Protected Health Information
I hereby authorize the following entities, their re-insurers, or other organizations performing business or legal services in connection with the Purpose above and their respective legal representatives ("Entities") to receive, use, and disclose my protected health information for the Purpose listed above: Guided Benefits, NYAPartners, The Wellness Program Manager, and the program Trustee.
Please note injectables are not covered except for insulin and epi pens. Other drugs may have age/condition limitations.

(i) the Plan; (ii) the Trust, (iii) its Trustee(s); (iv) the Trust's third party administrator; and (v) medical stop-loss insurance companies that may indirectly insure any health benefits provided by the Plan.
(i) Your self-insured employer; (ii) the employer's marketing representatives or brokers; (iii) The Trust, (iv) its Trustee(s); (v) the Trust's third party administrator; and (vi) excess or reinsurance carriers backstopping any obligations of the Trust.
I authorize Entities to disclose my PHI between themselves and their affiliated companies, to re-insuring companies, to the plan administrator or plan sponsor. I further authorize any licensed physician, medical practitioner, healthcare provider, hospital, clinic, or other medical or medically related facility, insurance or re-insuring company, or other organization that has any record or knowledge of me to give Entities any and all PHI about me concerning diagnosis, treatment and prognosis for any physical or mental condition, including, but not limited to, all medical and healthcare records. I understand I have a right to inspect and copy my own PHI/Personal Information to be used or disclosed. I understand that failure to sign this Authorization will result in my application not being considered. I understand that my Personal Representative or I have a right to receive a copy of the authorization form. A simulated, faxed or copied image of this Authorization shall be as valid as the original.

IV. Term of Authorization
I further agree this Authorization will be valid until we have completed its determination of my eligibility for coverage or for 12 months from the date signed, whichever is less.

V. Right to Revoke
I understand I may revoke this authorization at any time by giving advance written notice to the entities listed above. Revocation of this authorization form will not affect actions Entities took in reliance on this form prior to receipt of the written notice of revocation.

I HAVE HAD FULL OPPORTUNITY TO READ AND CONSIDER THIS FORM. I UNDERSTAND THAT, BY SIGNING THIS FORM, I AUTHORIZE THE USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION DESCRIBED IN THIS FORM. I AGREE THAT A FAXED OR COPIED IMAGE OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL

○ **YES, I AGREE TO RECEIVE EMPLOYEE BENEFIT DOCUMENTS INCLUDING, BUT NOT LIMITED TO: PLAN DOCUMENTS, SUMMARY PLAN DESCRIPTIONS, SUMMARY OF BENEFITS AND COVERAGE, POLICIES, CONTRACTS, AGREEMENTS, LETTERS AND NOTICES THROUGH ELECTRONIC MEDIA USING A COMPUTER WITH INTERNET ACCESS. EMPLOYEES SHOULD FIRST EXAMINE ALL RELEVANT DOCUMENTS REQUIRED FOR THEIR PARTICIPATION IN THEIR EMPLOYER'S SELF-INSURED GROUP HEALTH BENEFITS PLAN, INCLUDING THE SUMMARY DESCRIPTION OF THE PLAN. HEALTH BENEFITS COVERAGE TO THE EMPLOYEE IS AVAILABLE FROM THE EMPLOYER'S SELF-INSURED GROUP HEALTH BENEFITS PLAN ONLY IF ALL REQUIRED INFORMATION IS ACCURATELY DISCLOSED BY THE EMPLOYEE.**

EMPLOYEE SIGNATURE ______________________ DATE ______________________