Midwest Security
INSURANCE COMPANIES

Group Number _____

Midwest Security Life Insurance Company
ENROLLMENT FORM

For 2 - 25 medical lives

A

Last Name	First Name	M.I.	Home Phone Number

Street Address	City	State	Zip Code

Marital Status ☐ Single ☐ Married Date _____ ☐ Separated Date _____ ☐ Divorced Date _____ ☐ Widowed Date _____

Occupation

Hours Worked Per Week	Date Employed Full Time	Gross Monthly Salary

Employer Name Street Address

City State Zip Code

FOR HOME USE ONLY

Effective Date _____

Individual Number _____

Occupational Code _____

B

Coverage Selected: ☐ **Select Coverage** ☐ **Preferred Community Health Plan (POS)** - Complete Primary Care Physician Election Form

Deductible: _____ **Coinsurance:** _____ **Coinsurance Maximum:** _____

Network: _____

Group Health: ☐ self only ☐ self and spouse ☐ self and dependent children ☐ self, spouse, and dependent children

Group Life and AD&D: $_____

Dependent Life: ☐ yes ☐ no

Short Term Disability Income: $_____

Dental: ☐ self only ☐ self and spouse ☐ self and dependent children ☐ self, spouse, and dependent children

Complete the Waiver of Coverage section (E) only if eligible benefits are being waived for either the employee, spouse, or dependent children.

C

	Sex	Family Member's Names (include relationship if different last name) (Last (First) (M.I.)	Date of Birth (Mo/Dy/Yr)	Social Security #	Hgt.	Wgt.	Full-time Student (Y or N)
Applicant							
Spouse							
Child							
Child							
Child							
Child							

Primary Beneficiary _____ Relationship _____

Contingent Beneficiary _____ Relationship _____

Are you or your dependents participating in other group coverage (not being replaced by this plan) or Medicare benefits? ☐yes ☐no

If yes, name individuals and coverage/company. _____

D

Portability Information: Complete to determine appropriate reduction of this plan's pre-existing condition limitation. Attach certification of creditable coverage from your prior plan if you are a new enrollee under the above employer's plan.

Prior Coverage Start Date: _____ End Date: _____

Covered individuals: _____ Prior plan or carrier name: _____

Reason for ending prior coverage: _____

E

I hereby certify that I was informed of the availability of coverage under the Policy. I have decided not to apply for coverage offered for (check those that apply):

Medical: ☐ self ☐ spouse ☐ dependent children

Dental: ☐ self ☐ spouse ☐ dependent children ☐ Other: _____

Reason for waiving coverage: _____

If waiving coverage, please sign below. Application for life coverage requires completion of Sections F and G.

_____ _____

Signature of Applicant **Date Signed**

F

1. Are you now actively at work on a full-time basis? ☐ Yes ☐ No
2. Is any dependent currently disabled or unable to perform their normal activities? ☐ Yes ☐ No
3. Have you or any dependent ever been postponed or refused medical or life insurance? ☐ Yes ☐ No
4. Have you or any dependent, **in the last 10 years,** received treatment (including medication) or been told by a member of the medical or mental health profession that you had:
   a) Disorders of the heart or blood vessels, chest pain, or high blood pressure? ☐ Yes ☐ No
   b) Paralysis, epilepsy, Parkinson's disease, nervous system disorders, or migraine headaches? ☐ Yes ☐ No
   c) Tumor, cancer or any malignancy, diabetes, kidney or liver disorders? ☐ Yes ☐ No
   d) Mental disorders, depression or other emotional disorders, alcohol or other drug abuse or addictions? ☐ Yes ☐ No
   e) Stomach, intestinal, or gall bladder disorders, rheumatism, arthritis, back or spinal disorders? ☐ Yes ☐ No
   f) Tuberculosis, asthma, shortness of breath, or other respiratory disorders? ☐ Yes ☐ No
5. Are you or any dependent currently pregnant? ☐ Yes ☐ No
   a) Have you or any dependent, in the last 10 years, received treatment (including medication), or been told by a member of the medical profession that you had: infertility, premature delivery, miscarriage, c-section, or any other complications of pregnancy? ☐ Yes ☐ No
6. HAVE YOU OR ANY DEPENDENT to be covered by this insurance had any other injury, illness, treatment, or been hospitalized during the past ten years which is not listed above or anticipate treatment or surgery? ☐ Yes ☐ No
7. Have you or any of your dependents, in the last 10 years, been treated or told by a member of the medical profession that you had Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or any sexually transmitted disorder? ☐ Yes ☐ No

If any of the above questions are answered "YES", please indicate the following information: (1) The attending physician name and address; and (2) Any additional details or information concerning diagnosis or treatment. Attach additional page if needed.

PATIENT NAME	MEDICAL IMPAIRMENT	DATE	CURRENT STATUS/MEDICATION AND DOSAGE
PHYSICIAN/HOSPITAL NAME	PHYSICIAN'S CLINIC AFFILIATION	CITY AND STATE	
PATIENT NAME	MEDICAL IMPAIRMENT	DATE	CURRENT STATUS/MEDICATION AND DOSAGE
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PATIENT NAME	MEDICAL IMPAIRMENT	DATE	CURRENT STATUS/MEDICATION AND DOSAGE
PHYSICIAN/HOSPITAL NAME	PHYSICIAN'S CLINIC AFFILIATION	CITY AND STATE	

G

Authorization to Obtain Medical Information

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance or reinsuring company, organization, institution or person, that has any records or knowledge of me, my spouse, or my minor children to give to Midwest Security Life Insurance Company or its reinsurers, any and all such information. To facilitate the rapid submission of such information, I authorize all said sources to give such records or knowledge to any agency employed by Midwest Security Life Insurance Company to collect and transmit such information.

I understand the information obtained by use of the Authorization will be used by Midwest Security Life Insurance Company to determine eligibility for insurance and eligibility for benefits under an existing policy. Any information obtained will not be released by Midwest Security Life Insurance Company to any person or organization except to reinsuring companies, the Plan administrator, Plan sponsor, insurance intermediaries, or other persons or organizations performing business or legal services in connection with my application, claims plan renewal, or as may be otherwise lawfully required or as I may further authorize.

I acknowledge that I have received a copy of the Authorization to Obtain Medical Information. I agree this Authorization shall be valid for two and one half years from the date shown below and that a copy of this Authorization shall be as valid as the original.

A person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Signed this _____ day of _____

_____ _____

Signature of Applicant (or parent or guardian if proposed insured is a minor)

Signature of Spouse