



GroupSecureSM Enrollment Form Member Information Change Form

If you are a late enrollee, or your group has 10 or fewer covered employees, you must complete the entire form. If your group has 11 or more covered employees, complete Parts 1, 3, and 4, unless otherwise instructed.

PART 1: This Enrollment Form is for: Employee Only Employee + Spouse Employee + Child(ren) Family Late Enrollment
 Addition of Dependent(s) Removal of Dependent(s) Address Change Beneficiary Change Name Change Termination Notice

Participating Organization:		Group ID Number:		
Employee Name: (Last)		(First)	(MI)	
Occupation:	Citizenship:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Height	Weight
Resident Address:		Mailing Address (if different from Resident Address):		
City/State/Country/Postal Code:		City/State/Country/Postal Code:		
Daytime Telephone:		E-mail:		
Identification or Social Security Number:		Date of Birth:		
Requested Effective Date:		Date Employed Full-Time (30 hours/week):		
Departure Date from US:	Destination:	Length of Stay:		

Dependent Information (Attach a separate sheet if needed)

Name (Last, Middle, First)		Date of Birth	Height	Weight	Citizenship	Identification Number
Spouse	<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /				
1 st Child	<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /				
2 nd Child	<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /				
3 rd Child	<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /				

For dependent children age 19 or older, please indicate name and address of college or university and number of hours enrolled.

I refuse coverage for: Myself Spouse Child(ren)

Reason for refusal: _____

I have been given the opportunity to participate in the group insurance plan offered through my employer and I have refused to participate in the coverage. I understand that if coverage is desired at a later date, I may be required to furnish, at my own expense, satisfactory evidence of insurability before coverage becomes effective.

Date: _____ Signature: _____

HCCMIS's privacy policies may be found at www.hccmis.com, or contact HCCMIS for a copy. The following questions must be answered for each person listed above. For any question answered "Yes," provide details of the medical condition on the reverse side of this form. (Attach additional sheets if needed.)

1. Are you currently pregnant, hospitalized or disabled?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Have you ever been diagnosed, treated or tested positive for Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), Lymphadenopathy Syndrome or any immune system Disorder?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Have you ever been diagnosed, treated (including medications) or tested for: cancer, diabetes, high blood pressure, neurological, or any cardiac, cardiovascular, heart or circulatory condition?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. During the last 24 months have you been diagnosed, treated (including medications) or tested for any medical, mental or nervous condition or problem?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. During the last 24 months have you been advised or recommended to have testing, treatment or surgery or do you anticipate testing, treatment or surgery for any medical or mental or nervous condition or problem?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

PART 2: The following questions must be answered for each person listed in Part 1. For any question answered Yes, complete details must be provided.

Have you EVER been treated for or been told that you have any illnesses, conditions, medical problems, disorders or other problems relating to any of the following:

6. Gallbladder, pancreas, or liver?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	18. Tumor, cyst, polyp or growth of any kind?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Joints or spine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	19. Sexually transmitted disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. Eyes, ears or nose?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	20. Heart or circulatory system?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9. Mouth, throat or jaw?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	21. Respiratory system?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
10. Chest pain?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	22. Nervous system?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
11. Headaches, paralysis or arthritis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	23. Digestive system?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
12. Convulsions or epilepsy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	24. Prostate?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
13. Elevated cholesterol?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	25. Muscular or skeletal system?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
14. Cancer or stroke?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	26. Reproductive system?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
15. Kidney or urinary system?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	27. Alcohol or drug dependency?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
16. Thyroid, breast or other glands?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	28. Mental health or psychological?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
17. Complicated pregnancy or delivery?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	29. Diabetes or sugar or blood in urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

For any question answered "Yes," please state the name of the family member (using the corresponding number from Part 1). Provide details of the condition including Condition, Diagnosis, Dates of Treatment, Type(s) of Treatment, Prognosis, Present Course of Treatment, Physician Name, Address and Phone Number. Attach additional pages, if necessary. Additional information may be requested, as needed.

Individual's Name	Condition/Diagnosis	Date(s) and Type(s) of Treatment/Prognosis	Present Course of Treatment and Degree of Recovery	Physician and/or Facility Name, Address, and Phone Number

PART 3: Beneficiary Information – For each individual applying for life insurance, please indicate:

Beneficiary Name:	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	Relationship to Employee:	Percent of Death Benefit:
Beneficiary Name:	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	Relationship to Employee:	Percent of Death Benefit:
Beneficiary Name:	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	Relationship to Employee:	Percent of Death Benefit:

PART 4 (Must be completed)

Has any person listed on this Enrollment Form, including dependents, been insured or covered for medical expenses under any individual or group policy or plan during the last 12 months? Yes No

If you answered Yes, the following is required: 1. Name of Person(s) 2. Copy of all Certificates of Creditable Coverage. Certificates of Creditable Coverage can be obtained from your prior insurer or employer. Failure to submit Certificates of Creditable Coverage may delay your Effective Date.

I have read the above statements and all attachments or they have been read to me. The statements are true and complete to the best of my knowledge and belief. I understand that any misrepresentation contained herein will void the insurance and all claims will be forfeited. I understand no coverage is effective until I am notified in writing. I authorize any licensed doctor, medical practitioner, hospital, clinic, health related facility, pharmacy, government agency, insurance agency, insurance company, group policy holder, employee or benefit plan administrator having information as to the care, advice, treatment, diagnosis or prognosis of any physical or mental condition, or the financial and employment status of the individual, to provide this information to HCC Medical Insurance Services.

Employee Signature: _____ Date: _____

Spouse Signature: _____ Date: _____