AMWINS™
CONNECT ADMINISTRATORS

*Marketed and Administered Exclusively by:*
AMWINS™ CONNECT ADMINISTRATORS

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# EMPLOYEE ENROLLMENT/PERSONAL HEALTH QUESTIONNAIRE (PHQ)

All questions must be answered or the form may not be accepted.

Please choose from the following: ❑ New Applicant ❑ Coverage Change ❑ Information Update ❑ COBRA Applicant ❑ Waiver

| | | | |
|---|---|---|---|
| Employee Name: | | Employer Name: | |
| Home Phone: | | Work Phone: | |
| Address: | | City: State: | ZIP Code: |
| Email Address: | | Marital Status: | |
| Date of Hire: | Currently Full Time? ☐Yes ☐No | Hours Worked per Week: | Salary: |
| Occupation: | Division: | Is Spouse Employed? ☐Yes | ☐No |

Are you planning to enroll in your employer's health insurance plan? ☐ Yes ☐No
*If you selected "No", please select one of the following, then skip the remainder of the form and sign the bottom of page 2.
☐ Covered by Spouse's Plan ☐ Do Not Want Coverage ☐ Not Eligible ☐ Other Reason _____

*If you selected "Yes", please complete the rest of this form.
Answer the following questions for yourself and eligible enrolling family members. Include additional sheets for detailed explanations or additional dependents.

Do you or your dependents described on this form have health coverage with another carrier? ☐ Yes ☐No Effective Date: _____ Termination Date: _____

Who is covered? ☐ Self ☐ Spouse ☐ All Other Carrier Name: _____ Policy #: _____

Will you or your dependents continue coverage with other carrier? ☐ Yes ☐No

Other coverage is through ☐ Individual Policy ☐ Spouse's Employer ☐ Medicare (if Yes, ☐ due to End Stage Renal Disease (ESRD)?)

## I. Demographic, Build and Tobacco Use

| | Relation to Employee | Member Name | Social Security Number | Gender (M/F) | Date of Birth (mm/dd/yyyy) | Height Ft. | Height In. | Weight (lbs) | Home Zip Code | Tobacco Use (Yes/No) |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Employee | | | | | | | | | |
| 2 | Spouse | | | | | | | | | |
| 3 | Child | | | | | | | | | |
| 4 | Child | | | | | | | | | |
| 5 | Child | | | | | | | | | |
| 6 | Child | | | | | | | | | |

## II. Coverage Information

| MEDICAL PLAN | DENTAL PLAN | VISION PLAN | LIFE INSURANCE | SHORT TERM DISABILITY | LONG TERM DISABILITY |
|---|---|---|---|---|---|
| Plan: _____ | Plan: _____ | Plan: _____ | ☐ Life Insurance/AD&D | ☐ Short Term Disability | ☐ Long Term Disability |
| ☐ Individual | ☐ Individual | ☐ Individual | ☐ Supplemental Life Benefit: _____ | ☐ Voluntary STD Benefit: _____ | ☐ Voluntary LTD |
| ☐ Individual & 1 Child | ☐ Individual & 1 Child | ☐ Individual & 1 Child | ☐ Dependent Life | ☐ NONE | ☐ NONE |
| ☐ Individual & Adult | ☐ Individual & Adult | ☐ Individual & Adult | ☐ NONE | | |
| ☐ Individual & Children | ☐ Individual & Children | ☐ Individual & Children | | | |
| ☐ Family | ☐ Family | ☐ Family | | | |
| ☐ NONE | ☐ NONE | ☐ NONE | | | |

## Life Insurance Beneficiary

| Beneficiary Name | Relationship | % |
|---|---|---|
| | | |
| | | |

## III. Medical Conditions and Treatments

Has any person listed above seen a medical provider, had treatment recommended, received care (including prescriptions) or been hospitalized for any of the following? ***Check "YES" or "NO" for each question. Please complete ADDITIONAL DETAIL TABLE on page. 3 for ALL "YES" answers.

| | | | | | |
|---|---|---|---|---|---|
| 1. Cancer (if yes, list location and type of cancer below)<br>Check One: ☐Stage 1 ☐Stage 2 ☐Stage 3 ☐Higher<br>Date of Remission: (If Applicable) | ☐Yes | ☐No | 6 . Arthritis (i.e. rheumatoid, osteo, psoriatic, gout) | ☐Yes | ☐No |
| | | | 7 . Autoimmune Disease (i.e. lupus, MS,) | ☐Yes | ☐No |
| | | | 8. Back Disorder (i.e. degenerative disk disease) Herniated disk, spinal fusion, spondylitis, strain) | ☐Yes | ☐No |
| 2. Cardiac or Heart Disease/Disorder<br>If YES, check all that apply:<br>☐heart attack<br>☐bypass surgery or angioplasty on single vessel, or<br>☐bypass surgery or angioplasty on multiple vessels;<br>☐ANY other heart conditions (list here)<br>(i.e. arrhythmia, aneurysm, heart failure, heart valve disorder, pace maker) | ☐Yes | ☐No | 9. Benign Growth (i.e. tumor, cyst) | ☐Yes | ☐No |
| | | | 10. Bowel (i.e. irritable bowel IBS, Crohn's ileitis) | ☐Yes | ☐No |
| | | | 11. Circulatory System Disease (i.e. stroke, arterial/vascular Diseases) | ☐Yes | ☐No |
| | | | 12. Kidney Disorder (i.e. nephritis, renal failure) | ☐Yes | ☐No |
| | | | 13. Liver Disease (i.e. cirrhosis, hepatitis A, B, C, E) | ☐Yes | ☐No |
| | | | 14. Mental Illness (i.e. mild or major depression, anxiety, Bipolar disorder or schizophrenia) | ☐Yes | ☐No |
| 3. Diabetes (if yes, list type 1 or 2) Type?<br>If yes, list 3 most recent HbA1c/fasting blood sugar levels:<br>1) 2) 3) | ☐Yes | ☐No | 15. Counseling | ☐Yes | ☐No |
| | | | 16. Muscle/skeletal/bone/joint disorder | ☐Yes | ☐No |
| | | | 17. Respiratory (i.e. asthma, allergies, pneumonia, COPD, Emphysema, bronchitis, sarcoidosis) | ☐Yes | ☐No |
| 4. High Cholesterol<br>If yes, list results from the 3 most recent readings:<br>1) 2) 3) | ☐Yes | ☐No | 18. Stomach (i.e. ulcer, acid reflux, GERD) | ☐Yes | ☐No |
| | | | 19. Substance Dependency (has anyone named in this application been evaluated or treated for alcoholism or chemical dependency, 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 illegal drug?) | ☐Yes | ☐No |
| 5. High Blood Pressure<br>If yes, list results from the 3 most recent readings:<br>1) 2) 3) | ☐Yes | ☐No | 20. AIDS or HIV+ | ☐Yes | ☐No |
| | | | 21. Transplants (if yes, list organ(s): | ☐Yes | ☐No |
| | | | 22. Birth Defects | ☐Yes | ☐No |
| | | | 23. Neurological (CP, Parkinson's. Alzheimer's, Epilepsy, Paralysis) | ☐Yes | ☐No |
| | | | 24. Blood Disorder (Anemia, Hemophilia) | ☐Yes | ☐No |

| | | |
|---|---|---|
| 25. Is anyone currently taking prescription medication(s)? | ☐Yes | ☐No |
| 26. Has anyone had any of the following for a serious illness in the past 5 years? | | |
| a) treatment | ☐Yes | ☐No |
| b) hospitalization | ☐Yes | ☐No |
| c) surgery | ☐Yes | ☐No |
| 27. Is anyone currently: | | |
| a) hospitalized or confined in a treatment facility | ☐Yes | ☐No |
| b) confined at home, incapacitated or incapable of self-support? | ☐Yes | ☐No |
| 28. Is any of the following pending? | | |
| a) treatment (medical treatment or diagnostic testing) | ☐Yes | ☐No |
| b) hospitalization | ☐Yes | ☐No |
| c) surgery | ☐Yes | ☐No |
| 29. In the past 5 years, has anyone enrolling had symptoms of any serious medical condition not yet indicated on this form? | ☐Yes | ☐No |

## IV. Pregnancy and Childbirth

| | | |
|---|---|---|
| 30. Is anyone pregnant? | ☐Yes | ☐No |
| a) The due date is _____ | | |
| b) Is this a High Risk Pregnancy, any complications or bleeding? | ☐Yes | ☐No |
| c) Previous C-Section or pre-term birth? | ☐Yes | ☐No |
| d) Are multiple births expected? If so, please check ☐Twins ☐Triplets ☐More | ☐Yes | ☐No |

*If you marked "Yes" to any item on Pages 1 & 2, please complete ADDITIONAL DETAIL TABLE below, or this form will not be accepted.

| ADDITIONAL DETAIL TABLE – Please Fill in Details Below for All Questions Answered "YES" | | | | | | | |
|---|---|---|---|---|---|---|---|
| Question # | Name of Individual | Condition/Diagnosis | Date of Onset | Last Date Treated | Treatment/Drug | Still Taking (Y/N) | Degree of Recovery |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

My signature declares that the answers and information presented on this application are complete and true for all Applicants to the best of my knowledge and belief, and this information will be used as the basis for underwriting. NOTICE: A person who knowingly and with intent to misrepresent on this application or statement of claim containing any false, incomplete or misleading information may be subject to denied claims.

I understand that the following parties may need to provide or collect information on me or my Dependent Applicants: Amwins Connect Administrators, Inc. and its reinsurers, any insurance support organization, related Business Associates, any consumer reporting agency, physicians, hospitals, clinics, and all persons authorized to represent these organizations for this purpose. I authorize any health care provider, hospital or medically related facility, pharmacy, or pharmacy related facility, consumer reporting agency, insurance or Reinsurance Company, having information about me or any of my Dependent Applicants to provide all such information as requested by Amwins Connect Administrators or its Business Associates or Agents.

I understand that this Authorization may be needed for the purpose of gathering information to make eligibility, underwriting and group rating determinations and includes any and all information regarding diagnosis, treatment, and prognosis or medical conditions including physical, mental, psychiatric, drug, alcohol, and prescription history. Unless revoked earlier, this Authorization will be valid for thirty (30) months after the date it is signed, and a photocopy of this authorization is as valid as the original. I understand that I can revoke this authorization at any time by giving written notice to Amwins Connect Administrators.

I hereby authorize those physicians, medical practitioners, hospital, clinics, veteran's administration facilities, medical information services, urgent care facilities, pharmacy, pharmacy benefit manager, health plan, and other medical or medically related entities, insurance or reinsurance companies, and consumer reporting agencies that have information available as to the present or former physical health condition, including drug or alcohol or domestic abuse, and/or treatment of me or my dependents to release any and all such information, including, but not limited to, medical records, health care provider notes, laboratory tests and results, diagnoses, treatment, and prognoses. I understand the information obtained by use of this authorization may be used to determine eligibility for issuance of health coverage and eligibility for benefits under existing health coverage for me and my dependents. This authorization is not applicable to psychotherapy notes. I agree that a photographic copy of this authorization shall be as valid as the original and that this authorization shall be valid for 2 ½ years from the date shown below. I further understand the information I authorize a person or entity to obtain and use may be re-disclosed and no longer protected by federal privacy regulations. I understand that I may request a copy of this authorization. I understand that I may revoke this authorization at any time in writing unless action has been taken in reliance on my authorization. Because this authorization is given as a condition of obtaining coverage, my revocation will not prevent the Insurer and/or Plan Sponsor from the right to contest a claim if another law so allows. Should I refuse to sign this authorization, I understand it may affect my enrollment in the benefit plan. All pages must be attached and complete, including this authorization for the application to be considered complete. Incomplete applications may be rejected.

Print Name _____ Applicant Signature: _____

Date Signed: _____