Employee Enrollment Form

Coalition of Detroit Public Safety Unions Trust

A. Basic Information

☐ New ☐ Change/Add ☐ Waiver Retirement Date________________ Start Date________________

Employer Name____ I elect to enroll for: ☐ HRA

B. Employee Information *This section must be completed*

☐ Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ Widowed

First Name ___________________________________ MI________ Last ____

Address______________________________ City______________________________ State________________ Zip__________________

Date of Birth ______________________________________ Social Security Number ____

Daytime Phone Number______________________________ Email Address____

☐ Retired ☐ Union Affiliation: DPOA DFFA DPLSA DPCOA

C. Dependent Information This section must be completed when enrolling your dependents (use additional paper if necessary)

Please complete the following for each affected individual.

First Name	MI	Last Name	Relationship	Date of Birth	Sex	Social Security No.**

D. Waiver *This section must be completed if declining to enroll*

I decline to enroll for ☐ Medical coverage and/or ☐ Prescription Drug coverage and/or ☐ Vision Coverage

☐ Myself ☐ My spouse and/or ☐ My children due to:

☐ Spousal coverage ☐ Existence of other health/vision coverage ☐ Other reason (explain)___________________________

Check one of the above boxes, then read and sign.

I understand that if I and/or my dependents, if any, waive coverage and desire to participate in the plan at a later date, coverage will be subject to treatment as a late enrollee and I may only apply at the next open enrollment period. I further understand that if I decline enrollment for myself or my dependents (including my spouse) because of other health coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that I request enrollment within 30 days after such other health coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my dependent, provided that I request enrollment within 30 days after such marriage, birth, adoption or placement for adoption. I have read and understand the "Important Information" located on the last page of this form.

Sign below if declining coverage

Employee Signature____ Date____

E. Other Insurance Information If there is any other health insurance coverage please complete the following

Insurance Company_______________________________________ Address____

City____ State_____________________________________ Zip_________________

Phone Number___________________________________ Policy Number____

Who is covered ☐ You ☐ Spouse ☐ Dependent

If any family member has Medicare, please check below and attach a copy of Medicare card

☐ You ☐ Spouse ☐ Dependent

Employee Signature____ Date______________________________________

F-CDPSU-EE-ABS-04/20 (04/14/20)

F. Employee Agreement/Authorization to Release HIPAA Medical Information *This section must be completed*

I apply to US Health and Life Insurance Company (USHL) for coverage. I declare: (1) all statements in this form are true to the best of my knowledge; (2) I have not withheld or omitted any material information. I understand my answers are the basis for USHL to issue a certificate of insurance. I agree that USHL is not bound by any statement made by or to any agent unless written in this form. I understand any fraud or intentional misstatement about medical history will result in: denial of a valid claim; and rescission, voiding or reformation of insurance. I certify I read the entire completed form. I understand no agent has authority to bind or alter coverage.

I authorize the Authorized Disclosers to give USHL or its legal representative any information about me or my dependents as to: (1) diagnosis, treatment and prognosis of any physical or mental condition; (2) drug or alcohol abuse; HIV/AIDS test results, or diagnosis and/or treatment; (3) non-medical information.

Authorized Disclosers: physicians; medical practitioners; hospitals; clinics; veterans administration facilities; other medical or medically related facilities; pharmacy benefit managers; insurers; reinsurers.

I understand USHL uses the information obtained to determine eligibility: (1) for new insurance; (2) for benefits under any existing policy.

My protected health information (PHI) is: (1) individually identifiable health information, including demographic information; (2) collected from me or created or received by a health care provider, a health plan, my employer, or a health care clearinghouse. This information must relate to: (i) my past, present, or future physical or mental health or condition; (ii) the provision of health care to me; or (iii) the past, present, or future payment for the provision of health care to me.

I authorize USHL to use and disclose my PHI only for the purposes of administering the insurance certificate including but not limited to treatment, payment and health care operations activities. I understand USHL may refuse to enroll me or determine that I am not eligible for benefits if I refuse to sign this authorization.

I can revoke this authorization at any time. I must send a written revocation to USHL at 8220 Irving Road, Sterling Heights, MI 48312. The revocation is effective only for future uses and disclosures of PHI. The revocation is not effective: (i) for information USHL already used or disclosed relying on this authorization or (ii) if the authorization was obtained as a condition of coverage.

USHL will not release any information except: to reinsurers or other persons or organizations performing business or legal services in connection with my application for insurance; for any claims; or as may be lawfully required; or as I may further authorize. Information that USHL re-discloses may not be protected by federal privacy laws.

I may request a copy of this authorization at anytime. This authorization is valid for 30 months from the date I sign it.

Employee Signature____ Date__________________________

Spouse Signature____ Date__________________________

(Required if spouse is enrolling for coverage)

Child Signature____ Date__________________________

(Required if child age 18 or older is enrolling for coverage)

Child Signature____ Date__________________________

(Required if child age 18 or older is enrolling for coverage)

Child Signature____ Date__________________________

(Required if child age 18 or older is enrolling for coverage)

Fraud Warning: Any person who, with the intent to defraud or knowingly facilitates a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, or conceals information for the purpose of misleading may be guilty of insurance fraud and subject to criminal and/or civil penalties.