



HMO

# FlagStaff™ DENTAL & LIFE

## ENROLLMENT FORM

Requested Effective Date \_\_\_\_\_ New App \_\_\_\_\_ Status Change \_\_\_\_\_

Client Name			Hire Date	Social Security Number	Sex M <input type="checkbox"/> F <input type="checkbox"/>
Employee Name: Last	First	M. I.	Occupation		Date of Birth
Street Address		City	State	Zip	Telephone #
Coverage Applying For →	HAP HMO <input type="checkbox"/>	Dental <input type="checkbox"/>	Life <input type="checkbox"/>	Dependent Status →	Single <input type="checkbox"/> Family 2+ <input type="checkbox"/>
Other Insurance Coverage? Yes <input type="checkbox"/> No <input type="checkbox"/>	If Yes, Insurance Company? _____			Insured? _____	

Dependent Name	Relationship	DOB	Sex	Soc Sec #	PCP Last Name	PCP's City	PCP #
1.	Spouse		M <input type="checkbox"/> F <input type="checkbox"/>				
2.			M <input type="checkbox"/> F <input type="checkbox"/>				
3.			M <input type="checkbox"/> F <input type="checkbox"/>				
4.			M <input type="checkbox"/> F <input type="checkbox"/>				
5.			M <input type="checkbox"/> F <input type="checkbox"/>				
6.			M <input type="checkbox"/> F <input type="checkbox"/>				

### Medical Information Bureau Pre-Notice

All information regarding your insurability will be treated as CONFIDENTIAL. **FlagStaff**, its agent {Employee Benefit Concepts, Inc. (EBC)}, or its re-insurers may report this information to the Medical Information Bureau (MIB). If you make application with or claim from another MIB member, information will be supplied upon request. Upon written request from you, MIB will disclosure any information it has in your file. You may seek correction of any information in your file in accordance with the Federal Fair Credit Reporting Act. The address of the Bureau's information office is: PO Box 106; Essex Station; Boston, MA 02112.

EBC and its re-insurers may also release information in your file to other insurance companies to which you have applied for life or health insurance.

### DECLARATION

### AUTHORIZATION

### ACKNOWLEDGEMENT

**I hereby declare** that the answers and statements are made by me, that they are true and complete to the best of my knowledge and that they are correctly and fully recorded. I understand that the insurance company may refuse to accept any applicant it deems unsatisfactory. I understand that no insurance is in force until I am properly notified.

**I authorize** any physician, medical practitioner, hospital, clinic, medical facility, insurance or reinsurance company, and/or MIB, to give to EBC or its reinsurers all medical and other personal information which it has and is needed to determine eligibility for this insurance. EBC may disclose these data to its reinsures, MIB or other insurance companies. I, and anyone authorized to act on my behalf, have the right to receive a true copy of this authorization. I agree that any true copy will be treated as a valid original. This authorization will remain in force until revoked by me in writing.

**I acknowledge** receipt of the Medical Information Bureau Pre-Notice. I further acknowledge that this Enrollment Form is a part of the insurance contract.

Please review this application for completeness. accepted.

Sign and date this application.

An unsigned application will not be

<b>X</b>		
Applicant Signature	City, State Signed	Date

Life Insurance Beneficiary	Relationship to You