Employer: SearchPros Staffing **Last Name:**
Desired Effective Date:
Level of Coverage: **Plan Chosen:**

BLACK WOLF CONSULTING, INC
SPECIALIZING IN EMPLOYER COST REDUCTION

Employee Health Evaluation & Enrollment Form

INSTRUCTION: THIS FORM IS TO BE COMPLETED BY THE EMPLOYEE

Employer Information

Employer Name: SearchPros Staffing	Date of Hire:	Effective Date of Coverage:

Employee Information

Last name	First Name	Middle Initial	Date of Birth		Social Security #	
Home Mailing Address	Street	Apt #	City		State	Zip Code
Home Phone #	E-Mail Address	Gender	Height	Weight	Tobacco User ☐ Yes ☐ No	
Level of Coverage Chosen :	**Marital Status:** ☐ Single ☐ Married (date: _____) ☐ Divorced (date: _____) ☐ Separated (date: _____) ☐ Widowed (date: _____)					

***Deductible Plans Available: circle your choice and write your answer under plan selection above**

◯~$500 ◯~$2000 ◯~$5000 ◯~$6350 Value Plan

If Applying for Dependent Coverage, Complete Section Below for all Dependents to be Covered:
(Common Law spouses are NOT eligible for coverage, unless required by law. Use additional paper if necessary.

	First Name & Middle Initial	**Last Name** *(if different from applicant)*	**Step-Child**	**Gender**	**Date of Birth**	**Height**	**Weight**	**Tobacco User (Yes or No)**	**Social Security Number**
Sp									
Ch1									
Ch2									
Ch3									
Ch4									

Medical Information

To the best of your knowledge, answer the following questions for yourself and all dependents you are enrolling. The information on this form is designed to assist in *VEBA Trust Plan* evaluation of your group.

1. In the past three (3) years has any person enrolling consulted a health care provider, received treatment (including prescription medications), or been hospitalized for any of the following conditions, disorders, or diseases?

	Yes	No		Yes	No
Brain or Nervous System	☐	☐	Thyroid or Pituitary Disorder	☐	☐
Nervous, Mental, or Emotional Disorder	☐	☐	Diabetes or Sugar in Urine	☐	☐
Drug or Alcohol Abuse	☐	☐	Disease of the Muscles	☐	☐
Epilepsy or Cerebral Palsy	☐	☐	Bone or Joint Disorder	☐	☐
Abnormal Blood Pressure	☐	☐	Arthritis, Rheumatism, Bursitis	☐	☐
Heart or Circulatory System	☐	☐	Disorders of Back or Spine	☐	☐
Chest Pain or Stroke	☐	☐	Lungs or Respiratory System	☐	☐
Blood Disorder or Varicose Veins	☐	☐	Emphysema, Tuberculosis, Chronis Obstructive		
Digestive or Gastrointestinal Tract	☐	☐	Pulmonary Disease, or Asthma	☐	☐
Cirrhosis or Hepatitis	☐	☐	Multiple Sclerosis or Cystic Fibrosis	☐	☐
Liver, Pancreas, or Kidney	☐	☐	Skin or Collagen Disease	☐	☐
Rectum, Prostate or Hernia	☐	☐	Cancer, Leukemia, or Hodgkin's Disease	☐	☐
Genitourinary System	☐	☐	Lymphatic Vessels or Glands	☐	☐
Breast or Reproductive Organs	☐	☐	Any Physical Deformity or Defect	☐	☐
Endocrine or Adrenal Disorder	☐	☐			

2. Are you or any dependent currently pregnant or undergoing fertility treatment?	☐	**Yes**	☐	**No**
3. Are you or any dependent anticipating surgery?	☐	**Yes**	☐	**No**
4. Are you or any dependent an organ or tissue transplant donor, recipient or candidate?	☐	**Yes**	☐	**No**
5. Is anyone applying for coverage currently disabled, restricted, or unable to perform the normal activities of daily living or self care?	☐	**Yes**	☐	**No**
6. Is anyone currently taking medication?	☐	**Yes**	☐	**No**
7. Have you been diagnosed, whether treated or untreated, with any condition, whether mentioned above or not?	☐	**Yes**	☐	**No**

For any "Yes" answers provided in the above section, list the details for each "yes" answer in the section below. Use additional paper if necessary.

Question No.	Person	Age	Medical Condition or Reason for Treatment	Type of Treatment	Medications & Dosages	Treatment Date(s)	Recovery Status

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Have you or your dependents been covered under this employer's plan or any other major medical plan(s) at any time in the past 12 months? Yes ☐ No ☐ If yes: a) Who was covered? ☐ Employee ☐ Spouse ☐ Child(ren)
b) Name of Carrier: _____ c) Carrier Phone #: _____ d) Policy/ID #: _____
e) Effective Date: _____ f) Termed Date: _____ g) Reason: _____

Signature (This form must be signed and dated)
I, the Applicant, understand, to the best of my knowledge, the information provided on this Employee Health Evaluation & Enrollment Form is complete and accurate. I, the Applicant, understand that if I have misstated or omitted any information on this form, *VEBA Trust Plan* reassess premium applied to my employer group and/or me, deny claims, or terminate *VEBA Trust Plan* coverage in accordance with applicable law. *VEBA Trust Plan*, its reinsurers, and their authorized representatives are authorized to obtain medical information in order to evaluate the information contained in this Employee Health Evaluation & Enrollment Form.

Applicant Signature: _____ Date: _____

Complete if you are WAIVING MEDICAL Benefits for you and/or your dependents

I waive medical benefits for: ☐ Employee ☐ Spouse ☐ Child(ren) ☐ Employee and Family
Reason for waiving benefits: ☐ Spouse's employer plan ☐ Medicare/Medicaid ☐ Military ☐ COBRA ☐ Individual
☐ Other:_____

If I have waived benefits for myself and/or my dependents (including my spouse) because of other health benefits, I may in the future be able to enroll myself and/or my dependents in this plan, provided that I request enrollment within 31 days after my other benefits end because of involuntary loss of benefits (divorce, death, legal separation, termination of employment, reduction in number of hours of employment). In addition, if I have new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependents, provided that I request enrollment within 31 days after the date of the event. I further understand that, other than these qualifying events, if this form is submitted after the enrollment period, I cannot enroll until the next annual enrollment period.

Applicant Signature:_____ ***Date:*** _____

Employee Statement / Authorization to Release Medical Information

I hereby apply for participation in my employer's Employee Health and Welfare Benefit Plan for myself and/or my dependents listed above and agree to abide by the terms, provisions, and limitations as outlined by the Plan Sponsor in the issuance of the Summary Plan Description. I declare all statements contained in this form are true and correct and that no material information has been withheld or omitted. I understand that any misstatements or failure to report information that is material to my qualification and participation may be used as a basis for rescission of my participation and/or denial of payment of claims. I agree no benefits will be effective until the date indicated by *VEBA Trust Plan*.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, the Veterans Administration, the Medical Information Bureau (MIB), or any other organization, institution, insurance or reinsurance company, to disclose and release any information in its possession about the medical history, mental or physical condition or treatments of myself and/or my dependents to *VEBA Trust Plan* or its designee. This authorization includes information about drug abuse, alcoholism, or mental health. I agree that a photographic copy of this authorization shall be as valid as the original and that said authorization shall be valid for the maximum length of time permitted by law. I understand that I have the right to copy this authorization upon request. I authorize my employer to deduct from earnings the contributions (if any) required towards benefits.

I understand that the plan is an employee health & welfare plan created under the Employee Retirement Income Security Act (ERISA) of 1974 and subject to the rules and regulations adopted by the United States Department of Labor and is not insurance subject to laws of the state in which I work or reside. This application will be part of the contract. Benefits are effective only after approval by *VEBA Trust Plan* or its designee and satisfaction of any probationary period.

Applicant Signature:_____ ***Date:*** _____

Beneficiary Information

Beneficiary Name: Relationship to Member:

Complete Address: Birthdate of Beneficiary:

Phone:

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