


The following 18 pages provide an overview to www.InstantEnroll.com:



INSTANT ENROLL
An Online Health Enrollment Application

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This is the first page the employee sees after entering their password and user ID. The employee must select "I Agree" and click the "Proceed" button to continue.

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Welcome to Instant Underwriter

This system allows you to fill out the information insurance companies require from individuals and their dependents who are applying for coverage. It is designed to make it easier for you to collect the necessary information and complete all the required insurance forms. It is not a substitute for your personal review and accurate entry of information. Before starting the application process, please read the following carefully.

- The application requires detailed information on you and your dependents such as Social Security numbers, current or previous coverage contact information and policy number(s), and coverage dates.
- The application also requires detailed information on any medical condition and/or medications for you and your dependents. Before you start this application, it would be helpful to collect dates of onset and/or recovery relating to medical conditions, medication names, dosage amounts, refill amounts, and other pertinent information.
- If, for any reason, you cannot locate the appropriate field(s) to enter information in the online application, please contact your broker to discuss the best way to address this situation. You also may enter this information in the Additional Information field on the Review Page at the end of the application.
- At any time, you may save the application and continue at a later time if needed.
- At the top and bottom of each page, there are "Previous" and "Continue" navigation buttons you use to go back or forward to each page. Use the navigation links on the left hand side of the page to print and view the insurance company applications and manage your passwords.
- You are required to provide accurate, complete, truthful, and not misleading information.
- After you have completed the application, your information will be transferred into the insurance companies' forms. It is your responsibility to review each application and confirm that the information is accurate, complete, and truthful. You can do this by using the Preview button beside each application.
- After you have fully reviewed each application, you will need to print out and sign the applications. Then, return the applications to your HR administrator in a sealed envelope. You must use Adobe Acrobat Reader 6.0 in order to print the applications. If you do not have Adobe 6.0 installed on your computer, click on the Get Acrobat Reader button below to go to the Adobe website for the free download of the program.

If you have already completed your questionnaire and simply need to print or reprint your form(s) please click on the "Print Application" link in the upper left hand corner.

THIS AGREEMENT CONSTITUTES A LEGAL CONTRACT BETWEEN YOU AND YOUR EMPLOYER AND GOVERNS YOUR ACCESS TO AND USE OF THE FORM WRITING SYSTEM NOTED BELOW IN ANY MANNER.

IF YOU HAVE BEEN GRANTED THE RIGHT TO ACCESS AND USE THIS SYSTEM IN YOUR CAPACITY AS AN EMPLOYEE OR REPRESENTATIVE OF A LEGAL ENTITY, THEN (1) BOTH YOU (AS AN INDIVIDUAL) AND THE APPLICABLE LEGAL ENTITY ARE BOUND BY THIS AGREEMENT, (2) YOU HAVE THE APPROPRIATE RIGHTS AND AUTHORITY TO ENTER INTO AND BIND YOU AND THE APPLICABLE LEGAL ENTITY TO THE TERMS OF THIS AGREEMENT, AND (3) ALL REFERENCES IN THIS AGREEMENT TO "YOU" AND "YOUR" INCLUDE YOU (AS AN INDIVIDUAL) AND SUCH LEGAL ENTITY.

IF YOU HAVE BEEN GRANTED THE RIGHT TO ACCESS AND USE THIS SITE AS AN INDIVIDUAL AND NOT AS AN EMPLOYEE OR REPRESENTATIVE OF A LEGAL ENTITY, THEN (1) YOU (AS AN INDIVIDUAL) ARE AGREEING TO BE BOUND BY ALL OF THE TERMS AND CONDITIONS CONTAINED IN THIS AGREEMENT, AND (2) ALL REFERENCES IN THIS AGREEMENT TO "YOU" AND "YOUR" REFER TO YOU PERSONALLY.

THIS IS A FORM WRITING SYSTEM ONLY. IT IS NOT DESIGNED AS A FULL MEDICAL UNDERWRITING PROGRAM. YOU ARE REQUIRED TO REVIEW AND PRINT THE INSURANCE CARRIER FORM(S), THEN SIGN AND SUBMIT THEM TO YOUR EMPLOYER OR BROKER.

The insurance company(ies) are responsible for medical underwriting. You understand that your application for coverage is on the basis of these statements and answers to the questions. You understand that these statements, answers, and subsequent information you provide are the basis for your coverage.

You understand that all information provided by you in this application must be truthful, accurate, complete, and up-to-date. You represent and warrant that you have provided and will provide truthful, accurate, complete and up-to-date registration information in this application. You understand that you must update the information in this application to include any condition or disease that may occur between the date of your application and the Effective Date of Coverage. You understand that if your application for new or additional coverage is accepted, that applicable coverage will not be effective until after you are notified of the Effective Date.

UPON COMPLETION, YOU HEREBY DECLARE ALL ANSWERS TO BE TRUE, ACCURATE, COMPLETE AND UP-TO-DATE TO THE BEST OF YOUR KNOWLEDGE AND TO ACCURATELY REPRESENT THE HEALTH OF THOSE PERSONS APPLYING FOR COVERAGE OR WAIVING COVERAGE. YOU UNDERSTAND THAT PROVIDING FALSE INFORMATION OR OMITTING RELEVANT INFORMATION IN THIS APPLICATION MAY RESULT IN THE DENIAL OF CLAIM(S) OR CANCELLATION OF COVERAGE FOR YOU AND/OR YOUR DEPENDENTS. IT IS THE RESPONSIBILITY OF THE APPLICANT TO CAREFULLY REVIEW EACH PRINTED APPLICATION AND CONFIRM THAT THE INFORMATION IS TRUE, COMPLETE, ACCURATE AND UP-TO-DATE.

I agree I disagree

After the employee selects "I Agree" and clicks the "Proceed" button, they can continue.

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The employee must complete the required fields.
 If the broker has uploaded the census, much of this information is already populated for the employee.

Employee Information

Please enter your information. Required fields are marked in yellow.

Enrollment Information

Employer:
 Reason for Enrollment:
 Effective Date:

Employee Information

Social Security Number	Birth Date	Birth State	Gender	Marital Status	Marital Event Date
<input type="text" value="125654587"/>	<input type="text" value="10/14/1983"/>	<input type="text" value="Other"/>	<input type="text" value="Male"/>	<input type="text" value="Married"/>	<input type="text" value="01/01/2000"/>
First Name		Middle Initial	Last Name		
<input type="text" value="John"/>		<input type="text" value="r"/>	<input type="text" value="doe"/>		
Address					
<input type="text" value="123 east harbor rd"/>					
<input type="text" value=""/>					
City					
<input type="text" value="spokane"/>	St	Zip	County		
	<input type="text" value="WA"/>	<input type="text" value="99207"/>	<input type="text" value="spokane"/>		
E-Mail					
<input type="text" value="johnr@instantbenefits.com"/>					
Home Phone	Work Phone & Ext	Mobile Phone	Fax		
<input type="text" value="2538528352"/>	<input type="text" value="4521586521"/>	<input type="text" value=""/>	<input type="text" value=""/>		
Height	Weight	Do you have dependent children?			
<input type="text" value="5'8"/>	<input type="text" value="140"/>	<input type="text" value="Yes"/>			
If you speak a language other than English as a primary language, please specify					
<input type="text" value=""/>					
Are you an Owner/Officer?	Occupation, Job Title, or Duties	Hire Date	Employment Status	Full-time Employment Date	
<input type="text" value="Yes"/>	<input type="text" value="system analyst"/>	<input type="text" value="10/13/2006"/>	<input type="text" value="Full Time"/>	<input type="text" value="10/14/2006"/>	
Hours Worked per Week	Salary	Salary Cycle			
<input type="text" value="40"/>	<input type="text" value="40000"/>	<input type="text" value="Hourly"/>			

The employee must fill out all required fields.

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Employer:
 Reason for Enrollment:
 Effective Date:

Employee Information

Social Security Number	Birth Date	Birth State	Gender	Marital Status	Marital Event Date
<input type="text" value="125554587"/>	<input type="text" value="10/14/1983"/>	<input type="text" value="Other"/>	<input type="text" value="Male"/>	<input type="text" value="Married"/>	<input type="text" value="01/01/2000"/>
First Name		Middle Initial	Last Name		
<input type="text" value="John"/>		<input type="text" value="r"/>	<input type="text" value="doe"/>		
Address					
<input type="text" value="123 east harbor rd"/>					
<input type="text" value=""/>					
City					
<input type="text" value="spokane"/>		St	Zip	County	
<input type="text" value="spokane"/>		<input type="text" value="WA"/>	<input type="text" value="99207"/>	<input type="text" value="spokane"/>	
E-Mail					
<input type="text" value="john@instantbenefits.com"/>					
Home Phone	Work Phone & Ext	Mobile Phone	Fax		
<input type="text" value="2536526352"/>	<input type="text" value="4521588521"/>	<input type="text" value=""/>	<input type="text" value=""/>		
Height	Weight	Do you have dependent children?			
<input type="text" value="5'6"/>	<input type="text" value="140"/>	<input type="text" value="Yes"/>			
If you speak a language other than English as a primary language, please specify					
<input type="text" value=""/>					
Are you an Owner/Officer?	Occupation, Job Title, or Duties	Hire Date	Employment Status	Full-time Employment Date	
<input type="text" value="Yes"/>	<input type="text" value="system analyst"/>	<input type="text" value="10/13/2006"/>	<input type="text" value="Full Time"/>	<input type="text" value="10/14/2006"/>	
Hours Worked per Week	Salary	Salary Cycle			
<input type="text" value="40"/>	<input type="text" value="40000"/>	<input type="text" value="Hourly"/>			

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The employee must indicate if they are applying or waiving coverage for themselves or their dependents.

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Benefit Selection

Select the coverages you would like to enroll for yourself and dependents.

I am applying for coverage for: (check all that apply)

Medical	<input checked="" type="checkbox"/> Myself	<input checked="" type="checkbox"/> My Spouse	<input type="checkbox"/> My Dependents
Dental	<input checked="" type="checkbox"/> Myself	<input type="checkbox"/> My Spouse	<input checked="" type="checkbox"/> My Dependents
Vision	<input checked="" type="checkbox"/> Myself	<input checked="" type="checkbox"/> My Spouse	<input checked="" type="checkbox"/> My Dependents

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If the employee waives coverage for any family member, the system requires that they select the waiver reason. If all family members are enrolling, this page is skipped.

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Enrollment Status

Listed below are your benefit selections. If you chose to enroll you and/or your dependents, the form will display your selection. If you chose to waive coverage for you and/or your dependents, please verify that you do not want to enroll by checkmarking the boxes and selecting the appropriate reason(s) for waiving coverage in the provided dropdown boxes.

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Type of Coverage	Coverage for Myself	Coverage for My Spouse	Coverage for My Dependents
Medical	Enrolled	Enrolled	Enrolled
Dental	Enrolled	Enrolled	<input checked="" type="checkbox"/> Waiving coverage for my dependents because <div style="border: 1px solid gray; padding: 2px; display: inline-block; width: 100px;">Individual Policy</div>
Vision	Enrolled	<input checked="" type="checkbox"/> Waiving coverage for my spouse because <div style="border: 1px solid gray; padding: 2px; display: inline-block; width: 100px;">Spouse's Group Plan</div>	<input checked="" type="checkbox"/> Waiving coverage for my dependents because <div style="border: 1px solid gray; padding: 2px; display: inline-block; width: 100px;">Cost</div>

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If the employee has indicated they are married or have dependent children, they will be required to enter this information here.

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Dependents

To add each dependent, complete the required fields with an asterisk and click the Add Dependent button before you continue.

If applicable, you will be required to add a spouse or domestic partner in this section. If you indicated you had dependent children, you will be required to add at least one dependent child in this section.

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Name	Relation	Select
mark.patel	Child	<input type="checkbox"/>
jack.nuse	Child	<input type="checkbox"/>
james.patel	Grandchild	<input type="checkbox"/>
sarah.patel	Spouse	<input type="checkbox"/>
greg.patel	Stepchild	<input type="checkbox"/>
julie.patel	Child	<input type="checkbox"/>
		<input type="button" value="Remove"/>

First Name M.I. Last Name Gender Relation
 Birth Date Birth State SSN Height Weight
 If last name differs from employee, please explain
 If dependent is age 19+, indicate student status School Grad Date
 If this dependent speaks a language other than English as a primary language, please specify
 Does this dependent reside at a different address than the employee?
 If yes, please give address Do you want dependent materials to go to this address?

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If the the assigned app has any specific questions, they can be answed here.

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Carrier Application Questions

Some carriers may require additional applicant information. Please answer all of the following questions. Questions that don't apply can be marked 'NA'. Once all questions are answered, click "Continue" to continue the application.

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Change current enrollment because of the following events:

Marriage?	Yes ▾
Divorce?	No ▾
Birth?	No ▾
Involuntary loss of coverage?	No ▾
Death?	No ▾
Court order (copy of order required)?	No ▾
Adoption	No ▾
Other?	No ▾

If other, explain event:

Date event occurred:

Has any insurance carrier refused, restricted (including waiver or condition), or rated any health coverage for you or any dependents listed on this application? No ▾

If yes, please explain (list applicant's name, medical condition and whether refusal, waiver, or restriction):

If yes, name of carrier:

If yes, refusal date:

Is your employer contributing toward this coverage? Yes ▾

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The Employee checks which categories of conditions they have.

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Health Categories

Have any covered members ever been treated for or diagnosed with any of the following conditions?

Please answer the following health category questions to the best of your knowledge by selecting either yes or no. For each "yes" answer given on this page, you will then need to select the specific condition(s) for that category on the following page. You may read through some of the related conditions for each category and follow the link to get a full list of all related conditions if not sure.

<p>1. Cancer/Oncology Examples of conditions for this category include but are not limited to: Abnormal Growth, Benign Tumor, Breast Cancer, Other related disease, disorder or problem, Colon Cancer, Cervical Cancer, Leukemia, Liver Cancer, Lung Cancer, Hodgkin's Lymphoma, Sarcoma. Please refer to the following link for a comprehensive list for all conditions relating to Neoplasms. Also refer to this site regarding Cancers.</p> <p style="text-align: right;">Yes No</p>	<p>2. Infectious/Parasitic Diseases Examples of conditions for this category include but are not limited to: bone infection, HIV, Sexually Transmitted Disease, Other related disease, disorder or problem, Polio. For a comprehensive list for all conditions, please click on the following link relating to Infectious/Parasitic Diseases.</p> <p style="text-align: right;">Yes No</p>
<p>3. Endocrine/Metabolic/Immune System Examples of conditions for this category include but are not limited to: AIDS, AIDS Related Complex, Diabetes, Gout, Other related disease, disorder or problem, Growth Disorder, Immune Deficiency Disorder, Pancreas Disorder. Please refer to the following link for a comprehensive list for all conditions relating to Endocrine/Metabolic/Immune System.</p> <p style="text-align: right;">Yes No</p>	<p>4. Blood Diseases and Disorders Examples of conditions for this category include but are not limited to: Anemia, Other related disease, disorder or problem, Hemophilia, Sickle-cell trait, Thrombocytopenia, Erythrocytosis, abnormal white blood cells. For a comprehensive list for all conditions, please refer to the following link relating to Blood Diseases and Disorders.</p> <p style="text-align: right;">Yes No</p>
<p>5. Mental Health/Chemical Dependency Examples of conditions for this category include but are not limited to: Alcohol Use Disorder, Substance Use Disorder, Depression, Drug Use, Eating Disorder, Schizophrenia, Suicide-attempt. For a comprehensive list for all conditions, please click on the following link relating to Mental Health/Chemical Dependency.</p> <p style="text-align: right;">Yes No</p>	<p>6. Brain/Neurological/Central Nervous System Examples of conditions for this category include but are not limited to: Alzheimer's Disease, Autism, Other related disease, disorder or problem, Central Nervous System Disorder, Concussion, Epilepsy, Fainting spells, Headaches, Learning Disability, Migraine, Multiple Sclerosis. For a comprehensive list for all conditions, please click on the following link relating to Brain/Neurological/Central Nervous System.</p> <p style="text-align: right;">Yes No</p>
<p>7. Heart/Circulatory System Examples of conditions for this category include but are not limited to: Blood Clot, Chest Pain, Heart Attack, Heart Disorder, Other related disease, disorder or problem, Heart Murmur, High Blood Pressure, High Cholesterol, Low Blood Pressure, Phlebitis, Stroke. Please click on the following link for a comprehensive list for all conditions relating to Heart/Circulatory System.</p> <p style="text-align: right;">Yes No</p>	<p>8. Respiratory System Examples of conditions for this category include but are not limited to: Allergy, Asthma, Blood Spitting, Bronchitis, Emphysema, Other related disease, disorder or problem, Pleurisy, Pneumonia, Shortness of Breath, Common cold, Tonsillitis, Whooping Cough, Tuberculosis. For a comprehensive list for all conditions, please click on the following link relating to Respiratory System.</p> <p style="text-align: right;">Yes No</p>
<p>9. Digestive/Intestinal System Examples of conditions for this category include but are not limited to: Chronic Diarrhea, Crohn's Disease, Glaucoma, Irritable Bowel Disease, Jaundice, Liver Disorder, Intestinal Disorder, Stomach Disorder, Other related disease, disorder or problem, Ulcer. For a comprehensive list for all conditions, please click on the following link relating to Digestive/Intestinal System.</p> <p style="text-align: right;">Yes No</p>	<p>10. Urinary System Examples of conditions for this category include but are not limited to: Kidney Disorder, Bladder Disorder, Kidney Stones, Neurogenic Bladder, Polycystic Kidney Disease, Kidney Failure, Urinary Incontinence, Urinary Tract Disorder, and other related disease, disorder or problem. For a comprehensive list for all conditions, please click on the following link relating to Urinary System.</p> <p style="text-align: right;">Yes No</p>
<p>11. Pregnancy/Reproductive System Examples of conditions for this category include but are not limited to: abnormal Pap Smear, Other related disease, disorder or problem, Cervicitis, Ectopic Pregnancy, Infertility, Irregular Bleeding, Miscarriage, Premature Birth, Breast Disorder. For a comprehensive list for all conditions, please click on the following link relating to Pregnancy/Reproductive System.</p> <p style="text-align: right;">Yes No</p>	<p>12. Skin Diseases and Disorders Examples of conditions for this category include but are not limited to: Allergy, Other related disease, disorder or problem, Skin Disorder, Skin Ulcer, Eczema. For a comprehensive list for all conditions, please click on the following link relating to Skin Diseases and Disorders.</p> <p style="text-align: right;">Yes No</p>
<p>13. Musculoskeletal System Examples of conditions for this category include but are not limited to: Arthritis, Back Disorder, Bone Disorder, Joint Disorder, Joint Replacement, Neck Disorder, Ruptured Disc, Other related disease, disorder or problem, Spinal Disorder. Please click on the following link for a comprehensive list for all conditions relating to Musculoskeletal System.</p> <p style="text-align: right;">Yes No</p>	<p>14. Congenital/Birth Conditions Examples of conditions for this category include but are not limited to: Club Foot, Club Hand, Congenital Heart Condition, Congenital Deafness, Other related disease, disorder or problem, Down's Syndrome, Low Birth Weight Related Condition. Please click on the following link for a comprehensive list for all conditions relating to Congenital/Birth Conditions. You may also refer to Neurology.</p> <p style="text-align: right;">Yes No</p>
<p>15. Transplants/Implants Examples of conditions for this category include but are not limited to: Breast Implant, Considered for Transplant, Prosthetic Device, Replaced Implant, Other Kidney Transplant, Liver Transplant, Blood and Marrow Transplants.</p> <p style="text-align: right;">Yes No</p>	<p>15. Transplants/Implants Examples of conditions for this category include but are not limited to: Breast Implant, Considered for Transplant, Prosthetic Device, Replaced Implant, Other Kidney Transplant, Liver Transplant, Blood and Marrow Transplants.</p> <p style="text-align: right;">Yes No</p>

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The Employee checks which conditions they have for each category chosen.

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Health Conditions

Have any covered members ever been treated for or diagnosed with any of the following conditions?

Check off all related conditions for each category that you said "yes" to on the prior page. You will then have a chance to fill out some details relating to that condition on the next page.

You must select at least one condition for each displayed category.

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Skin Diseases and Disorders

- | | |
|--|--|
| <input checked="" type="checkbox"/> Allergy | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Other skin disease, disorder or problem | <input type="checkbox"/> Skin Disorder |
| <input type="checkbox"/> Skin Ulcer | |

Musculoskeletal System

- | | |
|--|---|
| <input checked="" type="checkbox"/> Ankylosing Spondylitis | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Back Disorder | <input type="checkbox"/> Bone Disorder |
| <input type="checkbox"/> Bone Infection | <input type="checkbox"/> Carpal Tunnel |
| <input type="checkbox"/> Connective Tissue Disorder | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Joint Disorder |
| <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Knee Disorder |
| <input type="checkbox"/> Kyphosis | <input type="checkbox"/> Muscle Disorder |
| <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Neck Disorder |
| <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Osteogenesis Imperfecta |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Other musculoskeletal disease, disorder or problem |
| <input type="checkbox"/> Paralysis | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Ruptured Disc | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Spinal Disorder | <input type="checkbox"/> Spinal Stenosis |
| <input type="checkbox"/> Spondylolisthesis | <input type="checkbox"/> Spondylosis |
| <input type="checkbox"/> Temporo-Mandibular Joint (TMJ) | <input type="checkbox"/> Tendonitis |

Other Symptoms, Signs and Injuries

- | | |
|--|--|
| <input type="checkbox"/> Abnormal Test Result | <input type="checkbox"/> Advised Further Testing |
| <input type="checkbox"/> Advised Further Treatment | <input type="checkbox"/> Advised Surgery |

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The Employee can choose whether certain conditions apply to them.

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Carrier Specific Health Conditions

Please answer the following carrier specific health questions to the best of your knowledge and provide any required additional details.

<input type="checkbox"/> No	Currently taking prescribed medication(s) for a condition not otherwise listed?
<input type="checkbox"/> Yes	Do you have any current or previous insurance coverage (health, dental, life, etc) other than what has been provided to you by your current employer?
<input type="checkbox"/> Yes	Are you or your spouse covered by Medicare?
<input type="checkbox"/> No	Has any named person incurred medical expenses or claims exceeding \$10,000 in the past 24 months?
<input type="checkbox"/> No	Used tobacco products in the last 12 months?
<input type="checkbox"/> No	Ever been convicted of a DWI/DUI or any other alcohol or controlled substance related incident?
<input type="checkbox"/> No	Currently receiving disability for worker's compensation or payments from an auto carrier for an injury?

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The Employee can provide details about their conditions.

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Health Condition Details

Please select your family member and the corresponding condition for which you answered "yes" in the previous section(s) and click on the "Go" button. To the best of your knowledge, please provide some details relating to that condition by filling out the following required fields and then click the "Add Condition" button. If you selected "Yes" to medications, you will have to provide details about that medication on the next page.

To add each new condition, select the family member and condition in the dropdown menus and complete the required fields with an asterisk and then click on the "Add Condition" button. When you are finished adding conditions, you can click on the continue button. Enter 'NA' if field does not apply. You may include any additional information at the end of the application process on the Review Page in the text box provided.

To remove a condition, simply check the box in the right panel beside a name and click "Remove". To update a condition you can click on the desired name.

Previous Continue

Name	Condition	Select
john.doe	Currently Disabled	<input type="checkbox"/>
john.doe	Ankylosing Spondylitis	<input type="checkbox"/>
mark.patel	Currently Disabled	<input type="checkbox"/>
mark.patel	Skin Allergy	<input type="checkbox"/>

Remove

Family Member: Condition:

Details for: [john.doe - Skin Allergy](#)

Condition/Diagnosis/Treatment Details:

Taking medications associated to this condition?

Ongoing/Chronic Condition:

Last Treated Date: Physician Name:

First Treated Date: Address:

Ongoing City: State: Zip:

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The Employee can provide details about their medications if any taken.

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Medication Information

Please select your family member and the corresponding condition for which you answered "yes" in the previous section(s). To the best of your knowledge, please provide some details relating to that condition by filling out the following required fields and then click the "Add Medication" button.

To add each new medication, select the family member and condition in the dropdown menus and complete the required fields with an asterisk and click on the "Add Medication" button. When you are finished adding medications, you can click on the continue button. Enter 'NA' if field does not apply.

To remove a medication, simply check the box in the right panel beside a name and click "Remove". To update a medication you can click on the desired name.

Previous
Continue

Name	Medication	Select
john.doe	stg	<input type="checkbox"/>
mark.patel	dfg	<input type="checkbox"/>
		Remove

Family Member:

Condition:

Medication:

Reason:

Still Prescribed:
 Date Last:
 Date First:

Dosage:
 Amount Per Day:
 Refills:
Cancel

Update Medication

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The Employee can provide details about their coverages if they selected "yes" to prior/current coverages.

Current and Previous Coverage

Please select your family member and the coverage type covered by that member. To the best of your knowledge, please provide some details relating to that coverage type by filling out the following required fields and then click the "Add Coverage" button.

To add new family coverages, select the family member and coverage type in the dropdown menus and complete the required fields with an asterisk and then click on "Add Coverage". When you are finished adding coverages, you can click on the continue button. Enter 'NA' if field does not apply.

To remove a coverage, simply check the box in the right panel beside a name and click "Remove". To update a coverage you can click on the desired name.

Name	Insurance Co	Effective Date	Select
john.doe	blue cross	5/5/2000	<input type="checkbox"/> <input style="border: 1px solid gray;" type="button" value=" Remove "/>

Family Member	Coverage Type	Plan Type	Effective Date	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
Insurance Company	Insurance Phone	Policy Number		
<input type="text"/>	<input type="text"/>	<input type="text"/>		
Has this coverage terminated?	If yes, termination date	Will you continue coverage?	Reason terminated	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
Employer Name	Employer Phone			
<input type="text"/>	<input type="text"/>			
Employer Address	City	State	Zip	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	

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If you selected medicare, you are required to fill in details.

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Medicare

Enter the medicare information for you and/or your spouse. Once the medicare information is added click Continue to continue the application.

Please attach copies of all Medicare Cards when you send your application(s).

Previous Continue

<p>Self</p> <p>Reason: Age</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 10%;"><input checked="" type="checkbox"/></td> <td style="width: 30%;">Part A</td> <td style="width: 20%;">Effective Date</td> <td style="width: 20%;">End Date</td> <td style="width: 20%;"></td> </tr> <tr> <td></td> <td></td> <td><input type="text" value="1/1/2000"/></td> <td><input type="text" value="12/31"/></td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td>Part B</td> <td>Effective Date</td> <td>End Date</td> <td></td> </tr> <tr> <td></td> <td></td> <td><input type="text"/></td> <td><input type="text"/></td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td>Part C</td> <td>Effective Date</td> <td>End Date</td> <td></td> </tr> <tr> <td></td> <td></td> <td><input type="text" value="1/1/2000"/></td> <td><input type="text" value="1/1/2000"/></td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td>Part D</td> <td>Effective Date</td> <td>End Date</td> <td></td> </tr> <tr> <td></td> <td></td> <td><input type="text"/></td> <td><input type="text"/></td> <td></td> </tr> </table>	<input checked="" type="checkbox"/>	Part A	Effective Date	End Date				<input type="text" value="1/1/2000"/>	<input type="text" value="12/31"/>		<input type="checkbox"/>	Part B	Effective Date	End Date				<input type="text"/>	<input type="text"/>		<input type="checkbox"/>	Part C	Effective Date	End Date				<input type="text" value="1/1/2000"/>	<input type="text" value="1/1/2000"/>		<input type="checkbox"/>	Part D	Effective Date	End Date				<input type="text"/>	<input type="text"/>		<p>Spouse</p> <p>Reason: </p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 10%;"><input type="checkbox"/></td> <td style="width: 30%;">Part A</td> <td style="width: 20%;">Effective Date</td> <td style="width: 20%;">End Date</td> <td style="width: 20%;"></td> </tr> <tr> <td></td> <td></td> <td><input type="text"/></td> <td><input type="text"/></td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td>Part B</td> <td>Effective Date</td> <td>End Date</td> <td></td> </tr> <tr> <td></td> <td></td> <td><input type="text"/></td> <td><input type="text"/></td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td>Part C</td> <td>Effective Date</td> <td>End Date</td> <td></td> </tr> <tr> <td></td> <td></td> <td><input type="text"/></td> <td><input type="text"/></td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td>Part D</td> <td>Effective Date</td> <td>End Date</td> <td></td> </tr> <tr> <td></td> <td></td> <td><input type="text"/></td> <td><input type="text"/></td> <td></td> </tr> </table>	<input type="checkbox"/>	Part A	Effective Date	End Date				<input type="text"/>	<input type="text"/>		<input type="checkbox"/>	Part B	Effective Date	End Date				<input type="text"/>	<input type="text"/>		<input type="checkbox"/>	Part C	Effective Date	End Date				<input type="text"/>	<input type="text"/>		<input type="checkbox"/>	Part D	Effective Date	End Date				<input type="text"/>	<input type="text"/>	
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The employee is asked to review all information. They can access and edit any part of the application from this page.

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Review

Please review your information. If you find an errors or omissions you can return to the appropriate part of the application to correct the information.

Employee Information

[Click here to edit](#)

Employee Name	SSN	Date of Birth	Hire Date	Marital Status
john doe	125654587	10/14/83	10/13/06	Married

Dependent Information

[Click here to edit](#)

Dependent Name	SSN	Birth Date	Relation
mark patel	125653214	01/01/00	Child
jack rusel	548789652	04/05/85	Child
james patel	154587896	01/01/06	Grandchild
sarh patel	125458965	01/01/85	Spouse
greg patel	232568956	01/01/05	Stepchild
julie patel	123654879	01/01/00	Child

Enrollment Status

[Click here to edit](#)

Type of Coverage	Status for Myself	Status for My Spouse	Status for My Dependents
Medical	Enrolled	Enrolled	Enrolled
Dental	Enrolled	Enrolled	Waiving coverage because Cost
Vision	Enrolled	Waiving coverage because Cost	Waiving coverage because Choose to be without insurance

Current or Previous Coverage

[Click here to edit](#)

Family Member	Policy Number
john doe	4112599

Medicare Information

[Click here to edit](#)

Family Member	Part A	Effective Date	Part B	Effective Date	Part C	Effective Date	Part D	Effective Date
Myself	Yes	1/1/2000fc			Yes	1/1/2000		

Medical Information

[Click here to edit](#)

Family Member	Medical Conditions	Medications
Myself	Ankylosing Spondylitis Currently Disabled	sfg
mark patel	Skin Allergy Currently Disabled	dfg

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You can print out the application from this page.

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Print Applications

IMPORTANT - PLEASE READ CAREFULLY BEFORE SUBMITTING THE ENROLLMENT FORMS

Step 1: You will need to have Adobe Acrobat Reader 6.0 installed on your computer to use the "Printable Version" of the insurance applications. If you do not have this program, click on the "Get Acrobat Reader" icon below and follow the directions on how to download this program for free. Once you have downloaded the program, you will have to open it to install. You will then be able to view and print your application(s). If you do not need Adobe Acrobat, continue to Step 2.



Step 2: Please review the application(s) to make certain that they are completed thoroughly. If an application is incomplete, the processing of your application(s) may be delayed.

Step 3: You may print the application(s) for your records. By clicking on a link below, Adobe Acrobat will open. You can print the application(s) from Adobe by clicking Print on the file menu.



Step 4: Send the printed applications as you have been instructed by your employer or broker.

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From the Employee Manager, only a broker has permission to print employee applications (click "print" below to view a sample application), but an employer can still edit employee records, upload a census, and reset passwords.

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Add Employee

Search:
Search
Clear

Census:
Browse...
Upload
example
Export Census

Employer: ABC Company						
	First Name	Last Name	User ID	Email	Status	Select
Edit Print Reset	David	George	DGeor1235	✉ j.george@someplace.com	Active	<input type="checkbox"/>
Edit Reset	Angela	Harris	AHarris445		Active	<input type="checkbox"/>
Edit Print Reset	Joe	Dawson	JDaws9984		Active	<input type="checkbox"/>
Edit Print Reset	Greg	Myers	GMyer5420	✉ gmyer@other.com	Active	<input type="checkbox"/>
Edit Print Reset	Dan	Swanson	DSwan4781	✉ dan_sawnsen@email.com	Active	<input type="checkbox"/>
Edit Print Reset	Anna	Davis	ADavis8455	✉ annad@internet.net	Active	<input type="checkbox"/>
Remove						

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From the Employer Manager, a broker can reset an employer's password, access employer and employee information, or batch print group applications.

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[Add Employer](#)

Search:

	Status	Employees	Employer Name	User ID	Broker Contact	Count	Application Status	Labels	Select
Reset	Active	Add/Edit	Acme Warehouse	AJohnson123	Anderson, Jake	54	20 Complete	View	<input type="checkbox"/>
Reset	Active	Add/Edit	Bank of Trust	KBreen64751	Brown, Joe	40	0 Complete	View	<input type="checkbox"/>
Reset	Active	Add/Edit	Coffee House International	LVand20120	Brown, Joe	12	10 Complete	View	<input type="checkbox"/>
Reset	Active	Add/Edit	Midwest, Inc.	GHalvers8945	Smith, Paul	22	22 Complete	View	<input type="checkbox"/>
									<input type="button" value="Remove"/>

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