



## 5. OTHER COVERAGE INFORMATION

This information you provide about other coverage (either prior or current) is necessary to determine whether you will have any waiting periods for pre-existing conditions. It will also help us to coordinate benefits with any other group health plan you may have. **To ensure proper credit towards the pre-existing clause of the policy, attach a Certificate of Creditable Coverage.**

1. Have you or your dependents had health insurance coverage with another carrier(s) at anytime during the last 12 months?  
 Yes  No If yes, answer the following:

**\*\*Provide information (below) about all the health insurance coverage you have had during the previous 12 months\*\***

Name of Policyholder \_\_\_\_\_ SS# of Policyholder \_\_\_\_\_

Effective date of policy \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Termination date of policy \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
*mo day year mo day year*

Reason coverage ended: \_\_\_\_\_

Type of Plan:  Group  Individual  Other Persons covered:  Self  Spouse  Child/ren

Name of insurance company \_\_\_\_\_ Telephone number \_\_\_\_\_

Was this a group policy offered through an employer?  Yes  No If yes, provide the following:

Name of employer \_\_\_\_\_ Telephone number ( \_\_\_\_\_ ) \_\_\_\_\_

2. Will you or your dependents continue to be covered under another health insurance plan while you are covered under this Unified Life Insurance Company plan?  Yes  No If yes, answer the following:

Who will continue to be covered:  Self  Spouse  Child/ren

Effective date of policy \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Type of plan:  Group  Individual  Other  
*mo day year*

Name of insurance company \_\_\_\_\_ Telephone number ( \_\_\_\_\_ ) \_\_\_\_\_

Is this plan through your spouse's employer?  Yes  No If yes, provide the following;

Name of employer \_\_\_\_\_ Telephone number ( \_\_\_\_\_ ) \_\_\_\_\_

3. Do you or your dependents currently have **Medicare** coverage?  Yes  No If yes, answer the following:

Name of person covered by Medicare \_\_\_\_\_ Medicare claim number \_\_\_\_\_

Is Medicare eligibility due to?  Over age 65  End-stage renal disease  Total disability

Part A effective date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Part B effective date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
*mo day year mo day year*

4. Are you or your dependents currently insured by **Guarantee Trust Life Insurance Company**?  Yes  No  
Were you or your dependents previously insured by **Guarantee Trust Life Insurance Company**?  Yes  No

## 6. HEALTH INFORMATION - Answer All Questions

**YOUR RIGHTS REGARDING GENETIC INFORMATION:** Louisiana law prohibits insurance companies from requiring genetic tests or disclosure of genetic test results. This law prohibits discrimination such as restricting the sale of coverage, refusing to renew or excluding coverage of an individual, imposing a rider that excludes coverage for certain benefits, or establishing differentials in premium rates or cost sharing based on genetic test results.

1. Has anyone named in this application taken any medications prescribed by a physician during the past year?  Yes  No  
If yes, complete the following. If additional space is needed, attach a separate sheet of paper.

NAME OF MEDICATION	DOSAGE	CURRENTLY TAKING	DATE LAST TAKEN
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	

2. Within the last 10 years, has anyone named in this application been seen, treated, counseled, or taken medication for:

- | Yes                         | No                       | Yes                         | No                       | Yes                          | No                       |
|-----------------------------|--------------------------|-----------------------------|--------------------------|------------------------------|--------------------------|
| a. <input type="checkbox"/> | <input type="checkbox"/> | n. <input type="checkbox"/> | <input type="checkbox"/> | x. <input type="checkbox"/>  | <input type="checkbox"/> |
| b. <input type="checkbox"/> | <input type="checkbox"/> | o. <input type="checkbox"/> | <input type="checkbox"/> | y. <input type="checkbox"/>  | <input type="checkbox"/> |
| c. <input type="checkbox"/> | <input type="checkbox"/> | p. <input type="checkbox"/> | <input type="checkbox"/> | z. <input type="checkbox"/>  | <input type="checkbox"/> |
| d. <input type="checkbox"/> | <input type="checkbox"/> | q. <input type="checkbox"/> | <input type="checkbox"/> | aa. <input type="checkbox"/> | <input type="checkbox"/> |
| e. <input type="checkbox"/> | <input type="checkbox"/> | r. <input type="checkbox"/> | <input type="checkbox"/> | bb. <input type="checkbox"/> | <input type="checkbox"/> |
| f. <input type="checkbox"/> | <input type="checkbox"/> | s. <input type="checkbox"/> | <input type="checkbox"/> | cc. <input type="checkbox"/> | <input type="checkbox"/> |
| g. <input type="checkbox"/> | <input type="checkbox"/> | t. <input type="checkbox"/> | <input type="checkbox"/> | dd. <input type="checkbox"/> | <input type="checkbox"/> |
| h. <input type="checkbox"/> | <input type="checkbox"/> | u. <input type="checkbox"/> | <input type="checkbox"/> | ee. <input type="checkbox"/> | <input type="checkbox"/> |
| i. <input type="checkbox"/> | <input type="checkbox"/> | v. <input type="checkbox"/> | <input type="checkbox"/> | ff. <input type="checkbox"/> | <input type="checkbox"/> |
| j. <input type="checkbox"/> | <input type="checkbox"/> | w. <input type="checkbox"/> | <input type="checkbox"/> |                              |                          |
| k. <input type="checkbox"/> | <input type="checkbox"/> |                             |                          |                              |                          |
| l. <input type="checkbox"/> | <input type="checkbox"/> |                             |                          |                              |                          |
| m. <input type="checkbox"/> | <input type="checkbox"/> |                             |                          |                              |                          |

3. In the spaces below, provide full details to questions for which you answered "Yes" above. If additional space is needed, attach a separate sheet of paper.

QUESTION NO. & LETTER	FAMILY MEMBER	DATES OF TREATMENT	DATE OF FULL RECOVERY	LIST THE CONDITION AND TYPE OF TREATMENT RECEIVED	NAME/PHONE NUMBER OF PHYSICIAN/HOSPITAL

## 7. DISCLOSURES, AUTHORIZATION AND SIGNATURE

The medical policy excludes coverage for health care services relating to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within six months prior to your enrollment date. This waiting period for pre-existing conditions complies with state and federal law and will not exceed a period of 12 months from your enrollment date if you enroll when you're initially eligible or during a special enrollment period, or a period of 18 months if you're a late enrollee. The policy's waiting period for pre-existing conditions will be shortened if you had prior qualifying coverage and had no lapse in coverage of 63 days or more (not including probationary periods). Prior qualifying coverage may be demonstrated by providing the Administrator with a Certificate of Creditable Coverage from your prior plan or health insurance carrier. If you don't have a Certificate of Creditable Coverage, contact your prior plan or carrier. Federal law requires your prior plan to provide you with such a Certificate if you send them a written request within 24 months of the date your coverage ended. If you aren't able to obtain a Certificate of Creditable Coverage after requesting one in writing, the Administrator will assist you in obtaining the necessary information to demonstrate prior qualifying coverage.

If applicable, I authorize my employer to make deductions from my earnings for my share of the cost of the coverage to which I am entitled. I have answered the above questions to the best of my knowledge and belief. I understand and agree that no coverage shall be in force until: the Administrator approves this application, eligibility requirements have been met, and certificate of insurance is issued, which shall not be valid unless the first period cost is paid. I further understand that this application will become a part of my certificate and any coverage afforded will be in consideration of the answers being true and complete and the premium paid. I also understand that any misstatements or failure to provide sought for information may be used as the basis for rescission, retroactive premium rating or nonrenewal of this insurance plan.

Signature of Applicant \_\_\_\_\_ Date Signed \_\_\_\_\_

## 8. WAIVER OF INSURANCE

If you wish to waive coverage for yourself and/or your dependents, please complete this section and sign below.

Employee Name \_\_\_\_\_ SS # \_\_\_\_\_ Date of Birth \_\_\_\_\_

### #1 Employee's Refusal of:

- Group Medical Insurance
- Dental Insurance

for:  myself  my spouse  my child/ren

### #2 Reason for Refusal:

- Insured under spouse's plan
- Insured under another plan
- Contribution required
- Other (list explanation) \_\_\_\_\_

I hereby certify that I have been given an opportunity to apply for insurance under the Group Insurance policy or policies provided by my employer, and that I have declined to do so.

I understand that by not applying for such insurance, I will not become insured under said policy or policies and will not be entitled to any benefits thereunder.

I further understand that if I and/or my dependents desire to apply for such insurance at a later date, coverage may possibly not be available or I may be required to provide health status information for purposes of group rate setting. Depending on applicable law, coverage may possibly not be issued or penalties such as deferred effective dates or pre-existing limitations may be imposed.

Signature of Applicant \_\_\_\_\_ Date Signed \_\_\_\_\_

## NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you and/or your dependents are waiving medical coverage, the following special enrollment periods may be available.

- If you and/or your eligible dependents (including your spouse) initially decline enrollment under this plan because of coverage under another group health plan and later you or your dependents lose eligibility for that other health plan (this includes COBRA coverage), then you and/or your eligible dependents may be able to enroll in this plan within 30 days of the other coverage ending.
- If you and/or your eligible dependents (including your spouse) initially decline enrollment under this plan because of coverage under another group health plan and later you or your dependents lose the employer contribution for that other plan, then you and/or your eligible dependents may be able to enroll in this plan within 30 days of the loss of the employer contribution for the other coverage.
- If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents provided that you request enrollment within 30 days after the event.

**Failure to specify that you are declining coverage because you have other coverage may waive your special enrollment rights as described above.**