NetCare
Life & Health Insurance

GROUP LIFE ENROLLMENT APPLICATION (GLEA)

Personal Information				
Group Name	Agency/Department			Date of Hire:
Last Name	First Name		M.I.	SS#
Mailing Address		Zip Code	Home #	Annual Salary
Date of Birth / Age	Occupation		Marital Status	Gender

Beneficiary Designation *(indicate full name of the beneficiaries. Do not use class designation e.g. my children)*

Name	Birthdate	Relationship	% of share

Note: Benefits due a minor beneficiary shall be released to his/her court-appointed guardian

Supplemental Coverages for Employees *(These coverages are subject to underwriting. Please fill-out the employee portion of the health questionnaire form)*

☐ I wish to enroll for additional $25,000 Supplemental Life Insurance and $25,000 Accidental Death & Dismemberment

Dependent Life Insurance *(Check one box only)*

☐ I wish to enroll my spouse and child(ren) for Dependent Life Insurance. Coverage may vary on Age

☐ I wish to enroll my child(ren) for Dependent Life Insurance. Coverage may vary on Age

☐ I wish to enroll my spouse for Dependent Life Insurance

Note: Please provide the details of enrolled dependents in the table below. For dependents not covered under the FSM Government Insurance carried by Individual Assurance Corporation, the Dependent portion of the health questionnaire must also be filled-out and they will be subject to underwriting.

Dependent Information

Name (Last, First, Middle)	Birthdate	Gender	Height	Weight	SS #
Spouse:					
Child:					
Child:					
Child:					
Child:					

I HEREBY DECLARE THAT:

- I am currently "actively at work".
- I understand that I should be actively at work on the date my insurance coverage with NetCare Life and Health Insurance Co. becomes effective.

Actively at work means performing normal duties for the Employer for a minimum of thirty (30) hours per week, at the usual place of employment, at an alternative work site at the direction of the Employer or at a location which the Employer requires the Insured to travel. For purpose of continuing, but not initially qualifying, an Insured will be considered Actively at Work on each regularly scheduled non-work day, or sick, personal leave, or vacation day approved by the Employer of thirty (30) or less consecutive days, if he/she was Actively at Work on the immediately preceding scheduled work day and immediately following scheduled work day, provided the Insured is not Totally Disabled.

Choose one below

☐ I am insured under the FSM Government Insurance carried by Individual Assurance Company prior to the effective date of my application with NetCare Life & Health Insurance Co.

☐ I am **NOT** insured under the FSM Government Insurance carried by Individual Assurance Company prior to the effective date of my application with NetCare Life & Health Insurance Co.

if the second option applies, please indicate details on the space provided and complete the employee column of the health questionnaire form: _____

I hereby request group insurance for myself and if the plan provides dependent insurance, for my dependents indicated above. I hereby authorize my employer or successor to make deductions from my earnings of the required contributions, if any, to apply toward premiums for this insurance policy.

If any beneficiary listed here dies before me, the interest of such beneficiary shall, unless otherwise provided above, accrue to the surviving beneficiaries, or if none, to my estate. I reserve the right to change any beneficiary listed above.

I understand that if my dependents' application for insurance is declined and desire to participate in the plan at a later date, evidence of insurability satisfactory to NetCare Life and Health Insurance Company must be furnished.

I hereby represent and agree that all the answers and statements on this application are full, complete, and true, to the best of my knowledge and believe and understand that the said answers and statements form the basis upon which insurance will be made effective.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION IN CONNECTION WITH ELIGIBILITY FOR GROUP INSURANCE

To all providers of medical or hospital service plans, prepaid health plans, employers, group policyholders, contract holders. For purposes of determining eligibility for insurance and eligibility for benefits under an existing policy, I authorize you to furnish NetCare Life and Health Insurance Company and its re-insurers or its representatives performing business or legal functions, any information available about the medical history, condition, treatment for myself, or the Dependents named in this application

I authorize NetCare Life and Health Insurance Company and its re-insurers to use and to re-disclose such information to any attending physician for treatment purposes, and when necessary, to inform the activities, to any person who has an authorization specifically permitting the re-disclosure and as may be permitted or required by law. I hereby reserve the right to ask and receive a copy of this authorization form.

_____ Employee Signature

_____ Date

_____ Witness Signature

Employee Name:_____ Date :_____

Height:_____ (in ft.)
Weight:_____(in lbs.)

Health Statement

	Employee		Spouse		Child(ren)	
1. Have you or any dependent been advised, diagnosed or treated for any of the following conditions? (Circle conditions to which "yes" answer applies)	Yes	No	Yes	No	Yes	No
a. Disorders of the eye, ear, nose, or throat?	☐	☐	☐	☐	☐	☐
b. Hepatitis, intestinal bleeding, ulcer or any disease or disorder of the stomach, liver or kidney?	☐	☐	☐	☐	☐	☐
c. Lungs or respiratory disorders including bronchitis, emphysema, asthma, pneumonia or allergies?	☐	☐	☐	☐	☐	☐
d. Disorders of the bone, joint, back, neck problems, arthritis deformity or amputation?	☐	☐	☐	☐	☐	☐
e. Brain, or neurological disorders, stroke, paralysis, seizures, or multiple sclerosis?	☐	☐	☐	☐	☐	☐
f. Cancer, tumor, cyst, polyps, growths or skin disorder of any kind, benign or malignant?	☐	☐	☐	☐	☐	☐
g. Chest pain, heart attack, murmur, palpitation, rheumatic fever or any disorder of the heart, blood or blood vessels?	☐	☐	☐	☐	☐	☐
h. Diabetes, gout, thyroid or any other gland disorder?	☐	☐	☐	☐	☐	☐
i. Epilepsy, nervous breakdown, Alzheimer's disease, Parkinson's disease?	☐	☐	☐	☐	☐	☐
j. Disorders of the reproductive system, Hemorrhoids, rectal polyps, breast, or prostrate?	☐	☐	☐	☐	☐	☐
k. High blood pressure? If yes, state latest reading _____	☐	☐	☐	☐	☐	☐
l. Acquired immune deficiency syndrome (AIDS), AIDS related complex (ARC), or (HIV)?	☐	☐	☐	☐	☐	☐
m. Sexually transmitted diseases (S.T.D.)	☐	☐	☐	☐	☐	☐
2. Have you or any dependent:						
a. Been examined, treated or received any consultation by any physician or practitioner in the last 5 years?	☐	☐	☐	☐	☐	☐
b. Ever been treated or ever received consultation for alcohol or drug abuse?	☐	☐	☐	☐	☐	☐
c. Received counseling for any psychological disorder, anxiety, depression, hyperactivity, eating, or sleeping disorders?	☐	☐	☐	☐	☐	☐
3. Are you or any dependent:						
a. Currently pregnant? If yes, how many months? _____	☐	☐	☐	☐	☐	☐
b. Ever been pregnant? If yes, how many times? _____	☐	☐	☐	☐	☐	☐
c. Ever been diagnosed or treated for any abnormal conditions of the female organs, menstrual periods, or experienced complications during pregnancy?	☐	☐	☐	☐	☐	☐
4. Are you taking any medication regularly?	☐	☐	☐	☐	☐	☐
5. Have you been absent from work for 2 or more consecutive weeks due to illness or injury?	☐	☐	☐	☐	☐	☐
6. Other than those identified above, have you or any dependent had, or been advised to have, currently contemplating medical attention, treatment, or surgery of any kind?	☐	☐	☐	☐	☐	☐

Declaration: I hereby represent and agree that all the answers and statements in this application are full, complete, and true, to the best of my knowledge and believe and understand that the said answers and statements form the basis upon which insurance will be made effective.

Continue to next page.

If you answered "Yes" to any of the health questions, please explain below.

Q#	Individual Name	Type of condition, treatment	Type of medication & dosage	Date Diagnosed	Current Status	Physician's Name / Clinic & Address

I understand that to be eligible for the insurance applied for the foregoing representations must be true to the best of my knowledge and shall, in the absence of fraud, be deemed representations and not warranties, and if same not be true, that I am not eligible for insurance for which application made and the Company's liability is limited to a return of the premium.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION IN CONNECTION WITH ELIGIBILITY FOR GROUP INSURANCE. To all providers of medical or hospital service plans, prepaid health plans, employers, group policyholders contract holders. For purposes of determining eligibility for insurance, and eligibility for benefits under an existing policy, I authorize you to furnish NetCare Life & Health Insurance Company and its re-insurers or its representatives performing business or legal functions, any information available about the medical history, condition, and treatment for myself, or the Dependents named in this Application.

I authorize NetCare Life & Health Insurance Company and its re-insurers to use such information and to re-disclose such information to any attending physician for treatment purposed, and when necessary, to inform the activities, to any person who has an authorization specifically permitting the re-disclosure and as may be permitted or required by law. I hereby reserve the right to ask and receive a copy of this authorization form..

_____ _____

Employee Signature Date

_____

Witness