TUCKER ADMINISTRATORS, Inc.
3800 Arco Corporate Drive, Suite 450
Charlotte, North Carolina 28273-3412
Tel: 704-525-9666 • Fax: 704-525-9534
www.TuckerAdministrators.com

EMPLOYEE INFORMATION

			Dept.#:		
			Effective date:		
Name:				SSN:	
Street Address:			City, ST, Zip:		
Email:	Marital Status:		Date of Birth:	Date of Hire:	Sex:
Phone:	Weight (lbs):	Height (ft/in):	Do you use Tobacco Products?	Type Used:	Yrs Used:
Waiting Period:			Job Title:		

LIST COVERED DEPENDENTS

Last Name, First Name *If you need additional space for dependents please list on separate sheet and attach to form.	Height(ft/in) Weight (lbs)	Tobacco User? (Y/N) Type / Yrs Used	SSN Required	Date of Birth	Sex
Spouse:					
Dependent:					
Dependent:					
Dependent:					
Dependent:					
Dependent:					

BENEFIT ELECTIONS

	_____Employee Only	_____Employee / Spouse
	_____Employee / Child	_____Family

DECLINATION OF ALL BENEFITS

I have been given the opportunity to participate in this plan and have elected not to do so because either my dependents or I are currently covered under another group health plan, which is listed below.

Current Health Carrier/Health Plan Sponsor:

Effective date of Coverage:

EMPLOYEE SIGNATURE:	DATE:

OTHER COVERAGE INFORMATION

Do you or any of your family members have any other medical coverage?

Persons covered by this coverage:

Company:	Policy#:

AUTHORIZATION OF BENEFIT ELECTIONS

I have read this application and certify that the statements made herein are complete and true to the best of my knowledge and belief. I accept the coverage provided by my employer's group plan and authorize the deduction from my earnings of any contribution I am required to make toward the cost of this coverage. On behalf of myself and anyone enrolled on or added to this application, I authorize any health care professional or entity to give my insurance plan and my employer or any of their designees, an and all records or information pertaining to medical history or service rendered by my insurance plan for any administrative purpose, including evaluation of an application or a claim, and for any analytical or research purposes. I also authorize on my behalf of my insurance plan the use of my Social Security Number for the purpose of identification.

EMPLOYEE SIGNATURE:	DATE:

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STATEMENT OF HEALTH INFORMATION

Please answer the following questions as completely as possible for all persons enrolling in this plan. By signing this form you are declaring that all statements are true and include the most complete information available to you has been provided. Misstatements of fact will result in an immediate termination of any and all insurance contracts.

Has any enrolling person been diagnosed with, treated for, had any medical advice, or have symptoms that may indicate any of the following:

1. Cancer, leukemia, multiple myeloma or tumor(s)?	y / n	y / n	13. Disorder of the thyroid, pituitary, adrenal or other glands?
2. Heart attack, high blood pressure, high cholesterol, or other heart / vascular disorder?	y / n	y / n	14. Disorder of the kidney, ureters, bladder or urethra?
3. Hemophilia or any other blood clotting disorder?	y / n	y / n	15. GERD (acid reflux), ulcer, or other disorder of the stomach or esophagus?
4. Aplastic anemia, sickle cell anemia, thrombocytopenia, agranulocytosis, or other anemia?	y / n	y / n	16. Crohn's disease diverticulitis, irrable bowel syndrome, or other disorder of the intestines?
5. Stroke, transient ischemic attach (mini stroke), or other cerebrovascular disorder?	y / n	y / n	17. Disorder of the bones, joints, spine, muscles, tendons or cartilage?
6. Emphysema, COPD, chronic bronchitis, Cystic Fibrosis or other respiratory disorders?	y / n	y / n	18. Current pregnancy? Due date
7. Parkinson's disease, Cerebral Palsy, epilepsy, migraines or other brain disorder?	y / n	y / n	19. High risk pregnancy, premature delivery, hydatidiform mole, or other pregnancy complication?
8. Multiple Sclerosis, Gullian-Barre, or other nervous system disorder?	y / n	y / n	20. Disorder of the reproductive organs?
9. HIV / AIDS or other immune disorder?	y / n	y / n	21. Genetic condition, congenital disorder or other birth defect?
10. Lupus, Scleroderma or other auto-immune disorder?	y / n	y / n	22. Mental / emotional disorder or alcohol / substance abuse?
11. Disorder of the liver, pancreas or gall bladder?	y / n	y / n	23. Major trauma or burn?
12. Diabetes or hypoglycemia (low blood sugar)?	y / n	y / n	24. Any other illness, condition or injury not referenced elsewhere on this form for which hospitalization has occurred or other treatment has been received in the last 5 years or is anticipated in the next 12 months?

DETAILS - Complete the following for any "Yes" answers

Question# & Name of family member	Dates of Treatment Ongoing Y/N	Recovery Date	Condition/Treatment and/or Medications	Name & address of physician / hospital

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION - PLEASE READ CAREFULLY

INFORMATION TO BE RELEASED: Any information deemed by Tucker Administrators, Inc. to be necessary for making an appropriate underwriting and/or claims adjudication decision. Including but not limited to: medical records, mental health records, substance abuse records, HIV records, results from diagnostic testing and/or telephonic interviews with the provider or the provider's authorized designee.

PURPOSE OF THIS AUTHORIZATION: Underwriting, premium rating, and other activities relating to the creation, renewal or replacement of stop loss insurance / excess loss insurance for an employer sponsored health and welfare benefit plan, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (as defined in C.F.R. Title 45 Subtitle A 164:501) For any administrative purpose, including evaluation of an application or a claim, and for any analytical or research purpose.

PARTIES AUTHORIZED TO RECEIVE THE INFORMATION: Tucker Administrators, Inc. (a third party administrator), Case Management Specialists (a third party medical consulting/case management firm), and/or any entity that Tucker Administrators, Inc. may reasonably see fit.

RIGHT TO REVOKE: You may revoke this authorization at anytime by writing to: Tucker Administrators, Inc. Attn: Claims/Group Administration, 3800 Arco Corporate Dr. Ste. 450, Charlotte, NC 28273. The revocation will be effective from the date received by Tucker Administrators, Inc.

SPECIAL NOTICE: Signing this release or any information obtained as a result will not affect your coverage under your employer's benefit plan. You do have the right not to sign the release.

PARTIES AUTHORIZED TO RELEASE THE INFORMATION:

PROVIDER'S NAME & PHONE NUMBER	RELATED QUESTION #	DATE OF BIRTH	ENROLLEE'S NAME

EMPLOYEE SIGNATURE:	DATE: