EMPLOYEE'S HEALTH INSURANCE ENROLLMENT FORM
WMI® MUTUAL INSURANCE™ COMPANY

P.O. Box 572450; Salt Lake City, Utah 84157
Phone: (801) 263-8000 Fax: (801) 263-1247

EMPLOYEE INFORMATION (Please Print)

Employee Name ____ Social Security # ____________________________

GENERAL INFORMATION
Will any portion of the premium be paid by or on behalf of the employer, either directly or through wage adjustments or other means of reimbursement? ☐ Yes ☐ No

Will any insured individual treat the health benefit plan as part of a plan or program for the purposes of sections 106, 125 or 162 of the Internal Revenue Code? ☐ Yes ☐ No If yes, is any part of the plan or program funded by the employer? ☐ Yes ☐ No

PREEXISTING CONDITION EXCLUSION AND PORTABILITY CREDITS:

Have you or any of your dependents been issued a certificate of creditable coverage within the past 63 days? ☐ Yes ☐ No

Benefits may not be payable for preexisting conditions for a period of twelve (12) months following your effective date of coverage (eighteen (18) months for a late enrollee). Note: The preexisting condition exclusion does not apply to children under the age of nineteen (19). A preexisting condition is an illness or injury for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period prior to the enrollment date of coverage. If a preexisting provision applies, each participant has the right to prove prior creditable coverage, including the right to secure a certificate from a prior plan of coverage. Let us know if you need assistance in obtaining a certificate of prior coverage. To obtain additional information regarding the preexisting condition exclusion, please contact the Claims Department, (801) 263-8000 x116 or (800) 748-5340 x116.

Name of prior carrier: ______________________________ Carrier Phone #: ____________ Policy #: ______________
Attach all certification forms verifying prior health plan coverage if they have been issued within the last 63 days.
☐ Form(s) are attached ☐ Form(s) will be forwarded when received from prior benefit plans ☐ This provision does not apply

---

STATEMENT OF HEALTH

1. Have you or any of your dependents been treated for or had symptoms of immune system or blood disorder, cancer, tumor, diabetes, stroke, heart attack, heart disease or disorder? ☐ Yes ☐ No
2. Are you or any of your dependents currently pregnant or partially or totally disabled or handicapped? ☐ Yes ☐ No
3. Have you or any of your dependents been treated for or had symptoms of any medical condition that may require surgical correction or hospitalization in the future? ☐ Yes ☐ No
4. Have you or any of your dependents ever had, been treated for, or been told you have abnormal blood pressure or other circulatory disorders, disorders of the nervous system, epilepsy, alcoholism, drug abuse, mental or emotional disorders, arthritis, bone, joint or back disorders, hernia, disorders of the stomach, intestines or rectum, liver disorders, lung or respiratory disorder, eye or ear disorder, disorder of the urinary tract, kidneys or reproductive systems? ☐ Yes ☐ No
5. In the past five years have you or any of your dependents had any mental or physical disorders, examination, hospitalization, treatment, medical advice or surgery not mentioned above? ☐ Yes ☐ No
6. Have you or any of your dependents taken prescription medication within the past 24 months? ☐ Yes ☐ No

LIST FULL DETAILS TO ANY QUESTIONS TO WHICH YOU HAVE ANSWERED "YES"

Person	Nature of ailment or Illness, prescription, etc.	Duration and Dates of treatment	Date of recovery	Name and Address of each Physician, Hospital, etc.

AUTHORIZATION

I authorize any physician, medical practitioner, hospital, clinic, any other provider of health care, or insurance company to disclose to WMI or its representatives all information and records of myself and my dependents relating to diagnosis, treatment, medical history, physical or mental condition, and evaluation thereof for which coverage by WMI is sought. I expressly waive on behalf of myself, my spouse and such dependents any legal action for such disclosure. This authorization shall remain valid for a period not to exceed twenty-four (24) months. A copy of this authorization shall have the same effect as the original.

I understand that WMI retains the right to retroactively adjust premium rates and/or rescind coverage if necessary due to any incorrect information that is provided on this application.

EMPLOYEE SIGNATURE ____ DATE ______________________________

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.