Nippon Life Benefits®

Nippon Life Insurance Company
of America
PO Box 25951
Shawnee Mission, KS 66225-5951

Small Employer Enrollment, Health & Waiver Form - SC

BEFORE SUBMITTING THIS FORM TO YOUR EMPLOYER PLEASE PROTECT THE CONFIDENTIALITY OF YOUR HEALTH INFORMATION.

Group number: _____

Please complete this section regarding your employment.	**Nippon Life Benefits to Complete (ONLY)**	
Company name	**Employee effective date:**	**Dependent effective date:**

Date of full-time employment | Job title/class | Number of hours worked per week

Employee work location – city, state, ZIP

Earnings

$ ☐ Yearly ☐ Weekly ☐ Monthly ☐ Hourly

A. Statistical Information: Thank you for your time and effort. Please provide the following information.

Your name (last, first, middle initial) | Social Security Number

Address (street or P.O. box) | City | State | ZIP code

Date of Birth | Phone number | County you live in

☐ Male ☐ Female ☐ Single ☐ Married

B. Benefit Election: Check your election option(s) below. Ask your employer what coverage(s) the group policy will cover.

	Medical	**Dental**	**Vision**	**Basic Life**	**Dependent Life**	**Short Term Disability**	**Long Term Disability**	**Supplemental Life**
Myself	☐ Elect	☐ Elect	☐ Elect	☐ Elect	☐ Elect	☐ Elect	☐ Elect	☐ Elect
	☐ Waive	☐ Waive	☐ Waive	☐ Waive	☐ Waive	☐ Waive	☐ Waive	☐ Waive
Spouse	☐ Elect	☐ Elect	☐ Elect					
	☐ Waive	☐ Waive	☐ Waive					
Child(ren)	☐ Elect	☐ Elect	☐ Elect					
	☐ Waive	☐ Waive	☐ Waive					

Medical plan options (if applicable to your group policy): _____ Deductible choice: _____ PPO network choice: _____

Reason for waiving coverage(s): (Please read the Waiving Coverage in Section H for information relating to consequences of refusing initial coverage.)

If Waiving Coverage, Information Will Appear on the Following Page(s)

C. Beneficiary Designation: Complete if your coverage(s) include group term life insurance.

Beneficiary for employee group term life insurance (Print as "Doe, Mary A.", not "Mrs. John Doe")

Last name	First name	Middle initial	Relationship
1.			
2.			
3.			

Unless otherwise provided herein, if two or more beneficiaries are named, the proceeds shall be paid in equal shares to the named beneficiaries surviving the insured. If no beneficiary has been named, any proceeds will be payable in accordance with the group policy.

D. Dependent Information: Please list your spouse and all eligible children that are applying for coverage. **110**

Spouse's name (last, first, middle initial)	Social Security Number	Date of Birth		
			☐ Male	☐ Female

Do you and your spouse work for the same employer? Yes No

NOTE: The Full-time student information below is not applicable to dependent children less than 26 years of age who are applying for Medical coverage.

Full name of dependent child(ren)	Date of Birth (mm/dd/yyyy)	Social Security Number (Applicants 18 & Over)	Full-time student (If yes, please complete questions a. through h. below)	Foster child	Handicapped child*	Male	Female
1.			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐	☐
2.			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐	☐
3.			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐	☐
4.			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐	☐
5.			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐	☐

If you need additional space please attach a separate piece of paper.

Are any of the dependents listed above full-time employees who are eligible for an employer sponsored health plan? **Yes** **No**

If yes, please identify: _____

To Be Completed By Member	Dependent 1	Dependent 2	Dependent 3	Dependent 4	Dependent 5
a. Does this child reside in the United States?	Yes No	Yes No	Yes No	Yes No	Yes No
b. Does this child live with you when not attending school?	Yes No	Yes No	Yes No	Yes No	Yes No
c. Was the child placed with you by an authorized state placement agency or by order of a court?	Yes No	Yes No	Yes No	Yes No	Yes No
d. Does this child reside in your home permanently?	Yes No	Yes No	Yes No	Yes No	Yes No
e. Do you provide more than one-half of this child's financial support?	Yes No	Yes No	Yes No	Yes No	Yes No
f. Is this child claimed as a dependent by you for federal income taxes?	Yes No	Yes No	Yes No	Yes No	Yes No
g. Please provide the date legal guardianship began (mm/dd/yyyy).					
h. Under what circumstances did you receive legal guardianship of this child?					

Is there any other pertinent information not covered above? (If so, please provide on a separate sheet of paper.)

Dependents must meet eligibility requirements. Foster child eligibility may be subject to approval by Nippon Life Insurance Company of America (Nippon Life Benefits).

***With respect to Medical or Vision Coverage:** If you have developmentally disabled/physically handicapped children over age 26 or any other age as required by state law, complete an Application to Continue Handicapped Child.

*** With respect to Dental coverage:** If you have developmentally disabled/physically handicapped children over age 19 or any other age as required by state law, complete an Application to Continue Handicapped Child.

Contact your employer for assistance with any questions.

Dependent coverage may be extended beyond the group policy limiting age if your child qualifies as a full-time student. We consider a full-time student to be a child who is attending an accredited school that has a regular teaching staff, curriculum, student body, and who attends school on a full time basis as his or her main focus, carries a minimum load of 12 credit hours, and is dependent on you for principal support.

NOTE: Future verification of full-time student status will be required at the time of claim submission. (If more than one student, please provide this information on a separate sheet of paper.)

Full-Time Student Name_____

Beginning Date of Attendance _____

E. Notice of Information Practices (To be read before completing the Health Information Section.)

In order to properly underwrite, we must collect information. **Please complete the Health Information in section G on pages 3 and 4.** In addition, we may contact sources besides yourself for personal data about any proposed insured, including spouse, employer, medical professionals or institutions, and insurance companies to which you may have applied for insurance in the past. The personal data may include age, medical history, job, income, habits and other personal characteristic information.

We will keep your data confidential. Only employees performing business transactions regarding your coverage will see your data. In certain circumstances, with your written authorization, we may provide data to government agencies (e.g., an insurance department of your state), or attending physicians. We may also provide statistical/unidentifiable information to insurance organizations who conduct large studies of insurance practices. You or your dependents, if applicable, have certain rights in connection with this request for coverage. Those rights are: (A) To find out what personal information is contained in Nippon Life Benefits files (medical information may be disclosed only to your attending physician); and (B) To correct or amend information in Nippon Life Benefits files. Upon written request, Nippon Life Benefits will furnish to you (or your dependent) information concerning: (A) The nature and scope of personal data in our records; (B) The types of disclosures which may be made; and (C) Rights of access to the information collected and how such information may be corrected or amended. We will respond to such written request within 30 days from the date of receipt.

Employee Name: _____ SSN: _____

Full name of dependent child(ren)	Date of Birth (mm/dd/yyyy)	Social Security Number	Full-time student	Foster child	Handicapped child*	Male	Female
			Yes No	Yes No	Yes No		
			Yes No	Yes No	Yes No		
			Yes No	Yes No	Yes No		
			Yes No	Yes No	Yes No		
			Yes No	Yes No	Yes No		
			Yes No	Yes No	Yes No		
			Yes No	Yes No	Yes No		
			Yes No	Yes No	Yes No		
			Yes No	Yes No	Yes No		
			Yes No	Yes No	Yes No		
			Yes No	Yes No	Yes No		
			Yes No	Yes No	Yes No		
			Yes No	Yes No	Yes No		
			Yes No	Yes No	Yes No		
			Yes No	Yes No	Yes No		

F. Electing Coverage – Please read if you are electing any coverage: **110**

I understand and agree with the following statements: My dependents, including step and foster children and any over the maximum age, are eligible based on plan provisions but those over the maximum age will be verified when a claim is filed. If the group policy requires my contributions, I authorize my employer to deduct from my pay. In applicable states, if medical coverage is an option under the group policy: I have been given a Notice to Enrollees regarding the preexisting condition exclusions and special enrollment rights, and I understand these provisions. They are part of this request for coverage. I agree Nippon Life Benefits is not liable for a claim before the effective date of coverage and all group policy provisions apply. I have read, or had read to me, the information and my answers on this form. My coverage can be cancelled at any time if I commit an act or practice that constitutes fraud or make an intentional misrepresentation of a material fact as prohibited by the terms of the plan or coverage. If signed in connection with an application, reinstatement or a change in benefits, this form will be valid for two years from the date below. I may revoke authorization for information not yet obtained. I understand data obtained will be used by Nippon Life Benefits for claims administration and determining eligibility for any coverage elected. Information will not be used for any purposes prohibited by law. Explanation of Benefits reflecting claim payments for myself and my dependents will be sent to my home address. I also understand collection of social security numbers for myself and my dependents will be used by Nippon Life Benefits only as allowed by law.

G. Health Information (Note: This information will not be used for any purpose prohibited by law.)

Answer only for those individuals requesting coverage. To prevent delays, answer each question and give full details to "Yes" answers. All statements and descriptions on this form shall be deemed to be representations and not warranties.

Employee's height _____ ft. _____ in. weight _____ lbs.	Spouse's height _____ ft. _____ in. weight _____ lbs.
Weight change in last year? _____ lbs. loss gain	Weight change in last year? _____ lbs. loss gain

1. ☐ Yes ☐ No	Is anyone currently using tobacco products, including cigarette, pipe, cigar or chewing tobacco? List name of person: _____
2. ☐ Yes ☐ No	Are you or any dependents included on this form currently pregnant, in the process of adoption, or undergoing or have undergone infertility treatment? If Yes, are you anticipating complications for you or your child or multiple births? ☐ Yes ☐ No Due Date or Date of Adoption: _____
3. ☐ Yes ☐ No	Is anyone on whom coverage is requested currently receiving medical treatment or taking medication?
4. ☐ Yes ☐ No	Has anyone been told of a need, or possible need for, or is anyone planning or scheduled for, physical therapy, a specialist consultation, surgery, hospitalization, medical treatment, psychotherapy, counseling, EKG, stress test, CT/MRI scan, blood test or any other medical tests or examinations?
5. ☐ Yes ☐ No	Does anyone have any physical or mental birth defect, developmental or learning disability, behavior disorder, or physical or mental impairment or condition?
6.	**In the past 5 years,** has anyone:
☐ Yes ☐ No	• Consulted a doctor, health care provider, or any medical specialist for persistent, lingering or prolonged fevers, night sweats, fatigue, tiredness or weakness?
☐ Yes ☐ No	• Been told by a doctor, health care provider, counselor, therapist, or any medical specialist of the need to reduce or discontinue the use of alcohol or drugs, or been treated for the use of alcohol or drugs?
☐ Yes ☐ No	• Had any surgery, hospitalization, observation room stay, or hospital emergency room treatment?
☐ Yes ☐ No	• Been treated, diagnosed or tested for HIV antibody, Acquired Immune Deficiency Syndrome (AIDS), or AIDS-Related Complex (ARC) by a physician or someone in the medical field?
	• Had any symptoms, diagnosis, consultation, treatment, taken medication, or received counseling for any of the following: ☐ Cancer ☐ Infertility ☐ Arthritis/Muscle Disorder ☐ Allergy/Respiratory/Asthma Disorder ☐ Tumors ☐ Liver/Hepatitis Disorder ☐ Bone/Joint Disorder ☐ Kidney/Bladder/Urinary Disorder ☐ Stroke ☐ Diabetes ☐ Multiple Sclerosis ☐ Neurological Disorder ☐ High Blood Pressure ☐ Endocrine Disorder ☐ Infectious Disease ☐ Mental/Nervous Disorder ☐ Heart/Circulatory Condition ☐ Digestive Disorder ☐ Blood Disorder ☐ Skin/Eye/Nose/Throat Disorder ☐ Immune System Disorder ☐ Systematic lupus Erthematosus ☐ Reproductive Disorder
7.	Have you or any of your dependents included on this enrollment form:
☐ Yes ☐ No	a. Within the past 5 years, been confined in a hospital, emergency room or other medical facility or had medical expenses in excess of $3,000 in any one year?
☐ Yes ☐ No	b. In the last 18 months, have been seen by any health care provider, including routine follow up or ongoing medical care, any consultation, treatment, therapy, advice or undergone any testing?
☐ Yes ☐ No	c. Been advised of the necessity or possibility of any future treatment, testing or surgery?

8. Are you or any of your dependents included on this enrollment form being treated for the following conditions, and if Yes provide the following information:

☐ Yes ☐ No a. Hypertension / High Blood Pressure: Last 3 blood pressure readings: Current _____

☐ Yes ☐ No b. Diabetes Mellitus (type): ☐ Type 1 (Juvenile Diabetes) ☐ Type 2 (Adult Onset Diabetes) Impaired Glucose Tolerance _____

If Yes, check treatment: ☐ Diet Controlled ☐ Oral Medications ☐ Insulin ☐ Insulin Pump

Date of Onset: _____

Include three Hemoglobin A1c Readings and Dates: 1. _____

2. _____

3. _____

☐ Diabetic Related Disorders: **(check all that apply)**

☐ Heart Disease ☐ Diabetic Coma ☐ Ketoacidosis ☐ Stroke ☐ Kidney Impairment (Nephropathy) ☐ Insulin reaction

☐ Visual Impairments (Retinopathy) ☐ Peripheral Vascular Disease ☐ Nerve impairments such as Numbness or Burning of Legs and Feet (Neuropathy)

☐ Yes ☐ No c. Mental or Nervous Disorder:

Diagnosis: _____

Treatment: **(check all that apply)**

☐ Inpatient Treatment ☐ Outpatient Treatment ☐ Counseling ☐ Prescription Medication(s)

If you answered yes to any of the above questions please provide full details below.

Name of person	Date diagnosed/treated	Duration of illness or condition

Diagnosis of illness or condition: explain treatment given, receiving or planned

Medications prescribed

Any current symptoms or

Names and addresses of

If Medical Information Has Been Entered It Will Appear on the Previous Page(s)

Name of person	Date diagnosed/treated	Duration of illness or condition

Diagnosis of illness or condition: explain treatment given, receiving or planned

Medications prescribed

Any current symptoms or problems

Names and addresses of doctors, hospitals or other providers

If more space is needed, please attach a separate piece of paper.

H. Authorization, Acknowledgment, and Signatures 110

I represent information, statements, and answers on this form and any attachments are complete and true to the best of my knowledge and belief. They are part of this request for coverage under the group policies. I agree Nippon Life Benefits is not liable for anyone's claim which happens or begins before the effective date of coverage by Nippon Life Benefits. I understand all group policy provisions for medical coverage will apply. If approved for life and disability coverages, all group policy provisions will apply including, but not limited to, preexisting conditions restriction, the actively at work and period of limited activity provisions. I further understand an agent or broker cannot change or waive any rates, benefits, or provisions of any group policy, if issued, without the written approval of an officer of Nippon Life Benefits. The date obtained by use of this authorization will be used by Nippon Life Benefits for claims administration and to determine eligibility for coverage. This information will not be used for any purposes prohibited by law.

- I authorize any doctor, health care provider, hospital, clinic or medically related facility, insurance company, consumer reporting agency or employer, that has any personal information, including physical, mental, drug or alcohol use history, regarding me or any dependent, to give to Nippon Life Benefits, its underwriters along with its agents and employees performing business transactions, any such data.
- I authorize Nippon Life Benefits to release any such data as required by law. When signed in connection with any application for, reinstatement of, or request for change in benefits, this form shall be valid for two years after the date shown below. I understand I may revoke this authorization for information not then obtained. A photocopy of this form shall be as valid as the original.

Waiving Coverage – Important information, please read if you are waiving any coverage.

I declare that I have been given an opportunity to apply for coverage. I understand if I refuse coverage:

(A) My dependents are not eligible for any coverage for which I am not covered.

(B) I cannot under any conditions reenter as a retired person.

(C) I (and my dependents) may enroll for medical coverage later; however, unless eligible for the special enrollment rights described in the Notice to Enrollees, I (and my dependents) will be subject to the late enrollee provisions.

(D) If I am enrolled in a health maintenance organization (HMO) sponsored by my employer, and if there is an open enrollment period under the policyholder or employer plan or the Nippon Life Benefits medical policy, I may transfer to the Nippon Life Benefits medical policy during that time.

(E) I (and my dependents) may enroll for dental coverage later; however, such enrollment could affect my initial level of dental benefits.

(F) I (and my dependents) may enroll for nonmedical coverage later; however, necessary proof of good health must be provided at my own expense and coverage will not become effective until approved by Nippon Life Benefits, subject to actively at work and period of limited activity provisions. Health conditions which may be present now or develop later may prevent me (or my dependents) from ever being approved for coverage.

Any person who knowingly and with intent to defraud any insurance company or other person, submits a statement of claim or any application form containing any materially false information or who conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime. Such actions may be considered felonies and subject to criminal and civil penalties, including imprisonment and fines.

Insured's Signature Required: _____ **Date:** _____

BEFORE SUBMITTING THIS COMPLETED FORM TO YOUR EMPLOYER, YOU MAY WISH TO PROTECT THE CONFIDENTIALITY OF YOUR HEALTH INFORMATION ON PAGES 3 AND 4, BY TAPING OR STAPLING THOSE PAGES TO ENSURE THE INFORMATION IS NOT VISIBLE.