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& union members

WBAT Workplace Benefit Advocates Team Insurance Services

P.O. Box 1232, Lakewood, CA 90714 ~ phone/fax (323) 298-1894 ~ Telephone (562) 244-5100; Fax (562) 425-5141

ENROLLMENT FORM FOR INSURANCE

Insured Name:_____ SSN_____

Home Phone_____Male__ Female__ Age__ dob__/__/__

Home Address_____City_____Zip_____

Employer: Los Angeles County

Phone_____ Fax_____ E-mail_____

Department_____Address_____City_____

Job title_____ Hire date_____ Yearly Salary _____

Emp #_____ Dept # _____

VOLUNTARY LTD BENEFIT	BI-WKLY PREMIUM
❑ $_____Max Benefit	$_____
❑ $500 Minimum Benefit	$_____
❑ $_____Other Benefit Amount	$_____

Please check one. You may select any amount between max & min in increments of 100.

Go to **wbatins.net** to download forms and for claims and dental information.

Initials _____

HEALTH QUESTIONS

Please answer the following questions. If you answer "YES" to any questions, please provide details in REMARKS below.
If you are applying for dependent coverage, please answer all questions for your eligible dependents.

Applicant: Height _____ Weight _____ **Spouse:** Height _____ Weight _____

	Yes	No
1. Have you or your dependents gained or lost 10 or more pounds during the past 12 months? If "Yes," how much _____	☐	☐
2. Have you or your dependents within the past 5 years: a) Received or been advised to receive any medication, treatment, surgery, therapy, testing, observation, or consultation by a physician, surgeon or other health care provider (including psychologist, counselor, dentist, chiropractor, osteopath, etc.) in any clinic, hospital, sanitarium, health resort or any other health related facility?	☐	☐
b) Used any illegal drugs?	☐	☐
3. In the past 5 years, have you or your dependents ever had, been treated for or been advised to seek treatment for persistent cough, fatigue or swollen glands, pneumonia, chest discomfort, muscle weakness, unexplained weight loss of ten pounds or more, patches in mouth, skin lesions, prolonged night sweats, visual disturbance or recurring diarrhea, fever or infection?	☐	☐
4. Are you or your dependents pregnant?	☐	☐
5. Have you or your dependents used tobacco, in any form in the past 12 months?	☐	☐
6. Have you or your dependents ever had, been medically diagnosed, treated or been advised to seek treatment for: arthritis; back, neck or joint disorder; asthma; emphysema or lung disorder; cancer or tumors; diabetes; alcohol, cocaine or drug abuse; high blood pressure; stroke or heart disease or disorder; depression; psychological counseling; mental, nervous or eating disorder; seizures; acquired immunodeficiency syndrome (AIDS) within the past 5 years? "Disorder" is defined as a disease, illness, injury and/or condition differing in any way from the usual or normal state and/or structure.	☐	☐

Name, address and telephone no. of personal physician _____

REMARKS-If you answered "YES" to any health question above, please provide details below.

Ques. No.	First Name	Description of illness, injury, or pregnancy, medication and treatment	Duration (dates) & no. of episodes	Residual effects/ results	Name and address of attending physician or hospital (*include zip*)

IMPORTANT NOTICE TO APPLICANTS - PLEASE READ CAREFULLY

MY SIGNATURE ON THIS APPLICATION CERTIFIES THAT I:

1) Apply for the coverages designated for which I am eligible under my employer's plan with Fortis Benefits Insurance Company. 2) Understand if coverages have been refused, I am not entitled to benefits under those coverages and that if I want to apply later, I must furnish at my own expense proof of good health satisfactory to Fortis Benefits Insurance Company. For Dental coverage, I understand that I will not be entitled to benefits until the expiration of the Late Entrant Limitation period specified in the policy. 3) Authorize any required deductions from my earnings. 4) Designate the beneficiary named on this application to receive any benefits payable in the event of my death. 5) Represent that all of the information on this application is complete, correct and true to the best of my knowledge and belief. 6) Understand that I must be actively at work the number of hours specified in my policy/ participation agreement to remain insured. 7) Have read, understood and received a copy of this application and the NOTICE REGARDING THE MEDICAL INFORMATION BUREAU, INSURANCE INFORMATION PRACTICES AND AUTHORIZATION TO OBTAIN AND FURNISH INFORMATION. 8) Understand that I have the right to select any dental care provider of my choice. 9) Understand that the dental plan includes a pre-estimate provision that will advise me in advance of the benefits I may be eligible for if the procedure is performed.

For your protection California law requires the following to appear on the form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

AUTHORIZATION TO RELEASE INFORMATION: For underwriting and claim purposes, I give my permission to: Any physician or other medical practitioner, hospital, clinic, pharmacy, insurance company, consumer reporting agency, employer, Medical Information Bureau to give Fortis Benefits or its reinsurers ALL INFORMATION on my behalf, including findings on medical care, dental care, alcohol or drug abuse information, psychiatric or psychological care or examination, or surgery, as they apply to me or my dependents who are to be insured. I give my permission to Fortis Benefits or its reinsurers to release any information to other life insurance companies as I may come in contact with.

I know that I have a right to a copy of this authorization. A photocopy of this authorization will be as valid as the original. This authorization will be valid for the term of coverage of the policy if health insurance or the duration of the claim for non-health insurance.

Employee's signature _____ Date _____

Spouse's signature (*if spousal coverage*) _____ Date _____

WBAT-Workplace Benefit Advocates Team Insurance Services
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(562) 244-5100 ~ Fax (562) 425-5141
Telephone/Fax (323) 815-0178
Wbatins.net

Your monthly deduction of $ _____ includes:

$ _____Voluntary Long Term Disability + $_____Optional Dental HMO + 1%Union dues (when applicable).

Plus $ 3.00 monthly administration fee and should commence in approximately two months. **Deductions will appear on your pay stub as code 448 AFSCME Local 685.** Your application acceptance of benefits offered does not constitute membership in AFSCME or any of its local unions.

For policy cancellation, a written request must be mailed or faxed to the insurer (888) 203-2323 and to WBAT ins (323) 298-1894 or (562) 425-5141 in order to cancel both policy and deductions. Cancellation notices must be received by the 15th of the month in order to take effect by the next pay period. Otherwise, cancellation will take effect the following month. Administration fees are non-refundable. A DI claim may be filed by contacting Customer Relations (800) 733-7879. Follow the prompt to Claims. Request to have claim form mailed or faxed to your home. Mail or fax claim to Fortis Ins, P.O. Box 419596, Kansas City, Mo 64141; fax (816) 881-8768. The insurer may report to the MIB, a non-profit membership organization of life insurance companies, which operates an informational exchange bureau on behalf of its members. If a claim for benefits is submitted within 12 mos of enrolling, the bureau, upon request, will supply the information it has in its file. WBAT Ins enrollment company helps facilitate payroll deduction but is in no way responsible for premiums deducted. We reserve the right to cancel payroll deduction or transfer pay codes at our discretion without prior notice . **This enrollment form may be photocopied and mailed to the address above. If you have any questions regarding your program(s), please contact your benefit representative.**

PAYROLL DEDUCTION AUTHORIZATION

By my signature, I certify that I: 1. am actively at work at least 20 hours/wk at the time of this enrollment; 2. authorize premium deductions from my pay check as of today's date and the auditor of the county of Los Angeles to adjust from time to time the amount of this deduction as may be required to comply with adjustments under the existing contract with the insurer. This authorization shall remain in effect until cancelled by me by written notice; 3. have read and understand the MIB insurances information practices and authorize the collection & release of information; 4. understand that I am not covered until approved; 5. understand that my name may be added to a reservice report whose purpose is to provide verification of products and services enrolled with WBAT Ins. Agents representing WBAT Ins will have access to this report. The list of all names in the report will be presented only to those included in the report; 6. represent that all of the information on this application is complete, correct and true to the best of my knowledge.

By my signature below, I affirm that I understand the above provisions that have been explained to me.

X_____ **Date:** _____

EMPLOYEE SIGNATURE

_____ _____

Printed Name **Name of Insured (if different)**

_____ _____

Employee # **Dept #**

Serving LA Co employees & union members **We go to bat 4U**