AGC HEALTH PLAN
ILLINOIS • MISSOURI
EST. 1960
www.agchealthplan.com

Enrollment Form & Individual Health Statement

Claims Administrator:
Consociate•Dansig
111 E. Decatur Street, P.O. Box 1068
Decatur, IL 62525
Phone: (888) 242-4357
Fax: (217) 451-9081-Eligibility changes

Employee Information (please type or print)

Social Security Number:__________ Employer:__________ Effective Date:__________

Last Name: __________ First Name: __________ Middle Initial: ______ Male / Female

Street Address: __________ City: __________ State: __________ Zip: __________

Date of Birth: __________ Single / Married / Widowed / Divorced Date of Employment: __________

Home Phone: __________ Work Phone: __________ Job Title: __________ Hours Worked per Week: __________

Benefit Coverage (Check the elected coverage)

Medical Benefit:

______ Employee Only ______ Employee and Child(ren)

______ Employee and Spouse ______ Family

Dental Benefits:

______ Employee Only ______ Employee and Child(ren)

______ Employee and Spouse ______ Family

PPO NETWORK SELECTION ______ Consociate Care ______ PHCS ______ HealthLink

If you do not select a PPO, a PPO will be selected for you based upon your home zip code.

Covered Dependent(s)

	First	MI	Last	SS#	Height	Weight	Date of Birth
Self							
Spouse							
Child							
Child							
Child							

Coordination of Benefits Information

Do your spouse or dependents have other coverage by another insurance carrier? (Circle answer) Yes or No

Type of coverage: _____ Health _____ Dental _____ Vision _____ Rx

List those with other coverage: __________

Insurance Company Name: __________ Insured's Name:__________

Address: __________ Insured's Date of Birth: __________

Policy Number: __________

Are you or any member of your family enrolled in medicare? (Circle answer) Yes or No

Life Beneficiary

Full Name:__________ Relationship:__________ Date: __________

Employee Waiver

Reason for declining/waiving coverage: (please check one)

______ Covered by spouse's coverage: __________Carrier name and I.D. number ______ Medicare

______ Enrolled in any other Insurance Carrier Plans: __________Carrier name ______ Other (Explain) __________

______ Spouse covered by employer's group medical coverage

Waiver right to participate: I acknowledge that the available coverage has been explained to me by my employer and I know that I have every right to apply for coverage. I have been given the chance to apply for this coverage and I have decided not to enroll myself and/or my dependent(s), if any. I have made this decision voluntarily and no one has tried to influence or pressure me to decline coverage. BY DECLINING THIS GROUP MEDICAL COVERAGE, I ACKNOWLEDGE THAT IF MY DEPENDENTS AND I APPLY FOR COVERAGE AT A LATER DATE, ANY PRE-EXISTING CONDITIONS WILL NOT BE COVERED FOR 18 MONTHS FROM THE EFFECTIVE DATE OF COVERAGE.

Signed by:__________ Date: __________

Employee signature

I hereby represent that my answers and statements as completed on this form are correct, to the best of my knowledge. I certify that each child named as covered under the AGC Medical Benefits plan is considered a "dependent" as defined in the plan. To all physicians, hospitals, clinics, dispensaries, sanitariums, druggists and all other agencies (including other insurance companies), you are authorized to permit Consociate•Dansig or its representative to obtain or view a copy of your records pertaining to my examination, treatment, history, prescriptions and medical expenses.

Signed by:__________ Date: __________

Employer Signature (FOR INTERNAL USE ONLY)

Did employee waive health coverage: Yes or No If no, Employee effective date of coverage __________

Signed by:__________ Date: __________

AGC HEALTH PLAN
ILLINOIS • MISSOURI
EST. 1960
www.agchealthplan.com

Enrollment Form & Individual Health Statement (continued)

Claims Administrator:
Consociate•Dansig
111 E. Decatur Street, P.O. Box 1068
Decatur, IL 62525
Phone: (888) 242-4357
Fax: (217) 451-9081-Eligibility changes

If you learn at any time before approval of coverage that any answers on this application are incomplete, you must advise the AGC Health Plan.

#	Question	Y	N
01	Is anyone currently under medical care or treatment?	☐	☐
02	Has anyone consulted, been tested, or had treatment by a doctor, chiropractor, counselor, therapist or other health provider within the past 3 years?	☐	☐
03	Has anyone been advised to be hospitalized, have tests, have surgery or take medication but has not done so?	☐	☐
04	Has anyone been hospitalized or had surgery in the past 5 years?	☐	☐
05	Has anyone had or does anyone have any birth defect, developmental or learning disability or physical or mental impairments?	☐	☐
06	In the past 5 years, has anyone had gallbladder problems, ulcers, chronic diarrhea, colitis, rectal disease, other digestive problems, pancreas problems, hepatitis, clorhogix, liver problems, hernia, stomach stapling or gastric bypass?	☐	☐
07	In the past 5 years, has anyone been unconscious or had epilepsy, seizures or convulsions?	☐	☐
08	In the past 5 years, has anyone had depression, stress or anxiety that interfered with daily life or received any counseling, psychotherapy or had a mental or nervous disorder?	☐	☐
09	In the past 5 years, has anyone been treated for use or abuse of drugs or alcohol or substance abuse or been told by any professional to reduce the use of alcohol, drugs or other substance?	☐	☐
10	In the past 5 years, has anyone had tuberculosis, asthma, pleurisy, emphysema or any disorder of the lungs or respiratory system?	☐	☐
11	Have you or any family member or any person residing in your household used tobacco during the past 2 years?	☐	☐
12	Has anyone ever had any heart trouble, heart attack, circulatory problems or any blood disorder?	☐	☐
13	In the past 5 years, has anyone had any back, neck or spinal problems or a joint disorder that required medical treatment?	☐	☐
14	Does anyone have multiple sclerosis or muscular dystrophy?	☐	☐
15	Has anyone had cancer, tumors, cysts, or growths (except for warts), breast lump, or any kind of skin disorder that required medical treatment?	☐	☐
16	In the past 5 years, has anyone had diabetes, gout, arthritis, thyroid disorder or a disorder of the lymph nodes or system?	☐	☐
17	Is any family member now pregnant?	☐	☐
18	Has anyone been evaluated for infertility or is anyone infertile?	☐	☐
19	Has anyone ever had a C-section or miscarriage?	☐	☐
20	Are you or your spouse financially responsible for an unborn child or anticipating adoption?	☐	☐
21	Has anyone had a blood disorder, tested positive for HIV, or been treated for or diagnosed with AIDS or any disorder of the immune system?	☐	☐
22	In the past 5 years, has anyone had surgery or treatment for obesity, bulimia, anorexia or weight control?	☐	☐
23	In the past 5 years, has anyone had a kidney disorder, urinary problems, albumin or sugar in the urine, pelvic inflammatory disease, incontinence, any disorder of the reproductive system, or venereal or other infectious disease?	☐	☐
24	In the past 5 years, has anyone been denied or turned down for other health or life insurance or been given a modified or rated policy?	☐	☐
25	Does anyone have a condition not indicated above for which medical treatment, counseling or care has been recommended or received in the past 5 years, or is expected to be received by any person applying for coverage?	☐	☐
26	In the past 5 years, has anyone had chest pain; rapid, slow or irregular heartbeat; or high blood pressure?	☐	☐

Prescription Medications

Is anyone currently taking any medicine, drugs or injections? If yes, please complete below:

Full name of individual	Name of medication	Reason for medication	Dosage	Date began/ended
				/
				/
				/
				/
				/
				/

Must be completed for any 'Yes' answers above:

Question #: ____________ Name of family member: ______________________ Diagnosis: ______________________
Began: ______________ Ended: ______________ Treatment: ______________________________
Remaining Symptoms: ____

Question #: ____________ Name of family member: ______________________ Diagnosis: ______________________
Began: ______________ Ended: ______________ Treatment: ______________________________
Remaining Symptoms: ____

AGC HEALTH PLAN
ILLINOIS • MISSOURI
EST. 1960
www.agchealthplan.com

Enrollment Form & Individual Health Statement (continued)

Claims Administrator:
Consociate•Dansig
111 E. Decatur Street, P.O. Box 1068
Decatur, IL 62525
Phone: (888) 242-4357
Fax: (217) 451-9081-Eligibility changes

Question #: ___________ Name of family member: ______________________________ Diagnosis: ______________________________
Began: ___________ Ended: ___________ Treatment: ______________________________
Remaining Symptoms: ______________________________

Question #: ___________ Name of family member: ______________________________ Diagnosis: ______________________________
Began: ___________ Ended: ___________ Treatment: ______________________________
Remaining Symptoms: ______________________________

Question #: ___________ Name of family member: ______________________________ Diagnosis: ______________________________
Began: ___________ Ended: ___________ Treatment: ______________________________
Remaining Symptoms: ______________________________

Question #: ___________ Name of family member: ______________________________ Diagnosis: ______________________________
Began: ___________ Ended: ___________ Treatment: ______________________________
Remaining Symptoms: ______________________________

If more space is needed, attach a separate page giving full details. Sign and date all pages.

Are you or any of your dependents currently disabled? ☐ Yes ☐ No
If yes, name of disabled person: ______________________________ Date of disability: ______________
Nature of disability: ______________________________

Has surgery, diagnostic testing or medical treatment been advised (but not yet performed) for any person listed on this application? ☐ Yes ☐ No

If yes, give the person's name and details: ______________________________

Has any person listed on this application incurred medical expenses or claims exceeding $10,000 in the past 24 months? ☐ Yes ☐ No

If yes, give person's name and details: ______________________________

Have you or any family members listed on this application suffered from, or now suffer from, any chronic or recurring ailments, illnesses or other departures from good health, regardless of whether a physician or other health care provider was consulted? ☐ Yes ☐ No

If yes, give person's name and details: ______________________________

Have you or any family members listed on this application received Social Security Disability or Worker's Compensation payments or are now eligible to receive such payments? ☐ Yes ☐ No

If yes, give person's name and details: ______________________________

Has any insurance company refused, restricted (including waiver or condition) or rated any health coverage for you and or any dependents listed on this application? ☐ Yes ☐ No

If yes, please list applicant's name, medical condition and whether refusal, waiver or restriction: ______________________________

AGC HEALTH PLAN
ILLINOIS • MISSOURI
EST. 1960
www.agchealthplan.com

Enrollment Form & Individual Health Statement (continued)

Claims Administrator:
Consociate•Dansig
111 E. Decatur Street, P.O. Box 1068
Decatur, IL 62525
Phone: (888) 242-4357
Fax: (217) 451-9081-Eligibility changes

Affirmation

I affirm the answers given on this application are complete and correct to the best of my knowledge and belief. I am providing the answers as part of the application procedure required by this the AGC Health Plan to enroll in its insurance coverage. I understand that the AGC Health Plan will rely on each answer in making its determination to extend coverage and to determine the type of coverage offered. I understand if this application contains any material misstatements or omissions, the AGC Health Plan may, within the first year of coverage, re-determine the appropriate premium rate level for my group. Further, the correct premium rates for that recalculated level will be applied retroactively to the original effective date of my group. I will promptly inform the AGC Health Plan in writing if anything happens before my coverage takes effect that makes any answer in the application incomplete or incorrect. The Trustees, in their sole discretion, may deny benefits or terminate coverage of a participant who has made a material misrepresentation, false warranty or omission in his or her individual health application. I understand and agree no coverage shall be in force until approved by the AGC Health Plan. If approved, coverage will be in force as of the effective date determined by the AGC Health Plan.

Statement of understanding and authorization for release of information

Be signing this application, I represent that all my answers are complete and accurate to the best of my knowledge and belief, and that I understand and agree to the following conditions:

- No independent producer, agent or employee of the insurance carrier, or of my employer can change any part of this application or waive the requirement that I answer all questions completely and accurately.
- The AGC Health Plan may terminate or rescind an insured's coverage for any misrepresentation, omission of fact by, concerning, or on behalf of any insured that was or would have been material to the AGC Health Plan's acceptance of a risk, extension of coverage, provision of benefits or payment of any claim.
- I authorize any physician, hospital or other health care provider to furnish the insurance carrier information regarding the history, diagnosis, or treatment of any symptom, condition, disease, illness, or accidental injury of any person named on this application.
- As proof of status of employment, I authorize my employer to release to the AGC Health Plan's appropriate documents, including by not limited to W-2 Wage and Tax Statements and other wage and tax summaries or forms.
- If this application is accepted, coverage for me and any eligible family members named on this application will begin on the date assigned by the AGC Health Plan.
- The group's master policy is the document that sets forth all the terms and conditions of my coverage. No agent or other person can change the terms of the master contract, any of its amendments, or this application, except with an amendment issued expressly for that purpose and signed by an authorized officer of the AGC Health Plan.

To any physician, health care provider, hospital, insurance or reinsurance company, the Medical Information Bureau (MIB) or any other insurance information exchange, or any employer:

Each of us authorizes you, on behalf of ourselves and any listed family members, to give medical information (including information about alcohol, chemical dependency, or mental treatment) you have about us to any interested carrier or is representatives. This authorization takes effect on the date shown below. This authorization shall be valid for 30 months from the date following my/our signature(s) below. A photocopy of this authorization is as valid as the original.

Signature of Applicant: ______________________________ Date: ______________

Signature of Spouse (if covered): ______________________________ Date: ______________