

THIS SECTION TO BE COMPLETED BY EMPLOYEE

Your health plan includes a Coordination of Benefits provision. The following information assists us in determining whether your health plan is the primary payor for you or your covered spouse or dependents:

Do you, your spouse or dependents have other insurance coverage? Yes No

If yes, what type of coverage? Medical Prescription Dental Vision

Insurance carrier name: _____

Carrier address & phone: _____

Policyholder's name: _____ Birthdate: _____

Group name/number: _____ ID number: _____

Coverage effective date: _____ End date: _____

List the individuals covered: _____

Your plan has a pre-existing condition exclusion period. If you, your spouse or dependents have other insurance coverage or are enrolling less than 63 days after the termination of other coverage, you may be eligible for credit toward your plan's exclusion period for pre-existing conditions. **Please submit a Certificate of Coverage from your other current or prior insurance plan so that we may credit ongoing or prior coverage and avoid any delays in processing your claims.**

I understand that my health plan may request or disclose health information about me or my dependents (who are listed for benefits coverage on the enrollment form) in order to facilitate health care treatment, payment or business operations necessary to administer health care benefits, or as required by law. Health information requested or disclosed may include, but is not limited to, claims records, correspondence, medical records, billing statements, imaging records, laboratory reports, dental records, or hospital records.

This acknowledgement does not apply to obtaining information regarding HIV/AIDS, psychotherapy notes, alcohol/drug treatment or genetic testing. A separate authorization will be used if information related to these health conditions is requested.

To the best of my knowledge the above is correct and I understand that if I provide false information Western Benefits can recover payment made, cancel my membership, and/or refuse to pay claims.

APPLICANT SIGNATURE _____ **DATE** _____

WHCRA Enrollment Notice: If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Please see your summary plan document for deductible and coinsurance levels. If you would like more information on WHCRA benefits, contact your Plan Administrator.

Description of Special Enrollment Rights: If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.