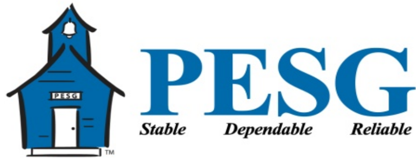

Group Medical Benefits Application

Michigan

Please complete this application in its entirety as completely and accurately as you can. When you are finished you may submit this by email to benefits@contractsubs.com, by fax at 615-361-4488 or by mail to PESG Benefits, 402 BNA Drive STE 202, Nashville, TN 37217. If you have any questions about this form or the benefit options in general, please contact us at (877) 514 - 8782 and select option #2 or email us at benefits@contractsubs.com.

Requested Effective Date ______ /______ /___________

Section #1: PESG Employee Information

Please fill out ALL fields completely and accurately.

Last Name	First Name	Middle	Date of Hire / /
Home Address		Date of Birth / /	Social Security Number - -
City	State	Zip	Primary Phone Number ( ) -
			Secondary Phone Number ( ) -
Gender ☐ Male ☐ Female	Marrital Status ☐ Single ☐ Married	Has anyone used tobacco products in the last 12 months? ☐ Yes ☐ No If Yes, then who_____________	
Email Address		Is anyone to be insured eligible for Medicare or Medicaid? ☐ Yes ☐ No If Yes, then who_____________	

Section #2: Spouse & Dependent Information

Please fill out ALL of the information below for your spouse and dependent children you wish to be on the plan. To be eligible, dependent children must be unmarried and 26 years of age or younger.

Spouse Name	Date of Birth / /	Gender ☐ Male ☐ Female	Social Security Number - -
Child Name	Date of Birth / /	Gender ☐ Male ☐ Female	Social Security Number - -
Child Name	Date of Birth / /	Gender ☐ Male ☐ Female	Social Security Number - -
Child Name	Date of Birth / /	Gender ☐ Male ☐ Female	Social Security Number - -
Child Name	Date of Birth / /	Gender ☐ Male ☐ Female	Social Security Number - -

If you have additional dependents you wish to cover, please provide their information on a separate sheet of paper and attach it to this application.

Section #3: Health Plan Selection

Choose a Plan	Choose a Coverage Level	Additional Voluntary Options
Plan 1 ☐	Employee Only ☐	Add Dental Insurance ☐
Plan 2 ☐	Employee + One ☐	Add Vision Insurance ☐
Plan 3 ☐	Full Family Plan ☐	Add Disability Insurance ☐
Plan 4 ☐		***Disability Insurance requires a separate application**

Section #4: Pre-Existing Condition Information

In the space provided below please check all of the conditions that you or any family members applying for coverage have been diagnosed or treated for currently or within the past 5 years. Please include the specific condition or description of the illness including any medications and the family member with the condition. **This information is required by all participants but will NOT affect coverage placement or rates.**

Condition	Details or Description	Family Member
☐ AIDS/HIV/ARC or other Immune Disorder		
☐ Alcohol or Drug Abuse		
☐ Amyotrophic Lateral Sclerosis/ALS (Lou Gehrig's Disease)		
☐ Any Surgery or Hospitalizations		
☐ Asthma, Allergies or other Respiratory		
☐ Cancer or other tumors		
☐ Coronary Artery Disease (including Heart Attack, Bypass, Angioplasty)		
☐ Cerebral Palsy		
☐ Cerebral Vascular Disease (including Stroke and TIA)		
☐ Crohn's Disease		
☐ COPD (Emphysema, Chronic Bronchitis)		
☐ Congestive Heart Failure		
☐ Cystic Fibrosis		
☐ Cirrhosis or any other Liver conditions		
☐ Diabetes		
☐ Epilepsy/Seizures		
☐ Guillan-Barre Syndrome		
☐ Hemophilia or other bleeding disorder		
☐ Hepatitis C, D or G		
☐ High Blood Pressure		
☐ Hodgkin's Disease		
☐ Huntington's Disease		
☐ Hydrocephalus		
☐ Infertility		
☐ Leukemia		
☐ Lupus		
☐ Muscular Dystrophy		
☐ Myasthenia Gravis		
☐ Paraplegia or Quadriplegia		
☐ Parkinson's Disease		
☐ Polycystic Kidney Disease		
☐ Pregnancy or Complications		
☐ Renal Failure		
☐ Rheumatoid Arthritis or other Bone/Joint		
☐ Scleroderma		
☐ Sclerosis (Multiple, Disseminated or Postero-Lateral)		
☐ Wilson's Disease		
☐ ANY Psychiatric Disorders (Alzheimer's, Dementia, Paranoia, Schizophrenia, Major Depression, Bipolar Disorder, Etc)		
☐ Sickle Cell Anemia		
☐ Transplant (Heart, Kidney, Liver or Lung)		
☐ Any other treatments or conditions not specifically mentioned above		

Section #5: ACH Authorization Information

This information is required to make monthly payments via ACH Withdrawal.

Professional Educational Services Group, LLC requires the monthly premium payment of Medical, Dental, Vision, Life, and Disability on an electronic payment basis. Payments will be taken every month on the 20th for the coverage period during the following month. If there is a problem with the withdrawal of funds you will be notified via email or phone and a 2nd attempt will be made around the 25th of the month. If funds are unable to be withdrawn for coverage your coverage will be cancelled effected on the first of the month following the missed payment. Please note: There will be a $25.00 fee assessed for fund requests that are returned or denied because of NSF.

Please include a blank, voided check or deposit slip from your designated account with this form.

Name of Financial Institution: ______________________________

What type of account is this? ☐ Checking Account ☐ Savings Account

______________________________ ABA/Routing Number (9 Digits)

______________________________ Bank Account Number (Including Zeros)

I authorize Benefit Advisor Group, LLC (BAG) to deduct my payments on behalf of Professional Educational Services Group, LLC from the checking or savings account listed above for the purposes of paying for benefits applied for. I understand that I control my payments and if at any time I decide to discontinue the payment or change the account information, I will notify BAG. I also understand that all information provided will remain confidential.

______________________________ Signature

____ / ____ / ____ Date

Section #6: Pre-Existing Conditions Exclusion & Waiver

This section is required if you wish to have the pre-existing conditions clause waived.

A pre-existing condition is any medical condition for which medical advice, diagnosis, care, or treatment was recommended or received in the 12 months prior to the date on which your application was received.

12 Month Pre-Existing Condition Waiting Period

This plan provides no coverage for treatment of a pre-existing condition for 12 months following your effective date of coverage. Unless a waiver of this exclusion is applied for below and granted in writing, it will apply to your plan.

Waiver of Pre-Existing Condition Waiting Period

You are eligible to apply for a waiver of the 12 month pre-existing condition waiting period provision if:

- Prior to your application for this coverage, you were continuously covered under one or more health plans for a total of at least 18 months, with no more than a 62-day break. Coverage may include group health plans, individual health insurance, Medicare, Medicaid, public health plans, military or federal benefit programs, Indian Health Services, freestanding prescription drug coverage or other health plans. Freestanding dental and vision coverage cannot be counted as prior health coverage.
- Your prior coverage was not terminated due to premium nonpayment or fraud

Application for Waiver of Pre-Existing Condition Waiting Period

☐ Yes ☐ No Immediately preceding this application, I had at least 18 months of continuous health insurance coverage under one or more plans, and there was no more than a 62-day break in coverage between any plans.

☐ Yes ☐ No My prior coverage was not terminated due to premium nonpayment or fraud.

PLEASE NOTE: You **MUST** provide a Certificate of Creditable Coverage (provided by your previous carrier) and any supporting documentation so we may determine if your pre-existing exclusion waiting period can be waived.

______________________________ Signature of Applicant

____ / ____ / ____ Date

Section #7: Authorization for the Use and Disclosure of Protected Health Information (PHI)

This authorization is required for coverage to be effective.

I hereby authorize any physician, medical practitioner, hospital, clinic, or other medical or medically related facility, Medical Information Bureau; Inc. or insurance companies that possess health information about me to furnish all such health information to Managed Care Administrators Inc., hereinafter called the Company, upon presenting this Authorization or a photocopy. Health information includes any medical treatment records, which includes treatment for drug abuse, alcoholism, AIDS or mental illness but specifically excludes psychotherapy notes.

The Company may obtain health information about me for the purpose of evaluating my application for insurance or my eligibility for benefits under an existing policy. This Authorization must be signed for me to be considered for the issuance of an insurance policy. Health information obtained by this Authorization will not be re-disclosed by the Company without my authorization except to re-insurers or authorized business associates, who may be involved with my application for insurance or otherwise permitted or required by law, in which case it may not be protected under federal privacy rules.

I acknowledge that I have read this Authorization, understand, and agree that this Authorization shall be valid for two years from the date of signature below. I may revoke this Authorization by sending written notice to Privacy Officer, Managed Care Administrators Inc., PO Box 50 Caledonia, MI 49316. Action taken in reliance of this Authorization will not be affected until written notice of revocation is received by the Company. Revocation of this authorization may result in the refusal of the Company to offer insurance coverage or pay benefits under a policy which has been issued.

______________________________ Signature of Applicant

____ / ____ / ____ Date

______________________________ Printed Name of Applicant

Section #8: Coodination of Benefits Disclosure

This information MUST be completed for claims to be processed accurately.

Do you, your spouse or your dependent(s) maintain other medical or dental coverage? ☐ Yes ☐ No

If yes, please fill out the section below and sign. If no, please sign below.

Subscriber's Last Name	Subscriber's First Name	Employer's Name

Insurance Company Name	Insurance Company's FULL Address

Insurance Company Phone	Other Coverage Type	Policy Number of Other Coverage
( ) -	☐ Single ☐ Family	

Please list all family members covered under the other policy.

If you, your spouse or any dependents are enrolled in Medicare please attach a copy of your Medicare card(s). Please check one of the following about status of person with Medicare:

☐ Actively Working ☐ Retired ☐ Under 65 years of age ☐ ESRD (end stage Renal)

______________________________ Signature of Applicant

____ / ____ / ____ Date

______________________________ Printed Name of Applicant

Section #9: Health Information Authorization - Claims Information

This authorization is required for coverage to be effective.

I hereby authorize any physician, medical practitioner, hospital, clinic, or other medical or medically related (dental or vision) facility, Medical Information Bureau; Inc. or insurance companies that possess health information about me to furnish all such health information to MCAI and AEG (for Dental) hereinafter jointly called the Company, upon presenting this Authorization or a photocopy.

Health information obtained by this Authorization will not be re-disclosed by the Company without my authorization except to re-insurers or authorized business associates, who may be involved with my application for insurance or otherwise permitted or required by law, in which case it may not be protected under federal privacy rules, acknowledge that I have read this Authorization, understand, and agree that this Authorization shall be valid for two years from the date of signature below. I may revoke this Authorization by sending written notice to Privacy Officer, MCAI, PO Box 50 Caledonia, MI 49316. Action taken in reliance of this Authorization will not be affected until written notice of revocation is received by the Company. Revocation of this authorization may result in the refusal of the Company to offer insurance coverage or pay benefits under a policy which has been issued.

	/ /
Signature of Proposed Insured or Parent if Proposed Insured is under 18	Date
Print Name of Proposed Insured	Application Number (if Known)

NOTE TO MEDICAL PROVIDERS This Authorization is designed to comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 also know as HIPAA.

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

1. Information About the Use or Disclosure

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary and that I may revoke it at any time by submitting my revocation in writing to the entity providing the information.

Patient Name:		**Patient SSN:**	- -

Persons/organizations authorized to provide the information: **Personal Doctors, Dentists, Medical Facilities, MCAI, and AEG (Dental)**

Persons/organizations authorized to receive the information: **Personal Doctors, Dentists, Medical Facilities, MCAI, and AEG (Dental)**

Specific description of information to be used or disclosed: **Health Benefit Related Information**

Specific purpose for the disclosure: **To discuss and process claims and claims related information**

Will the health plan or health care provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above?

This authorization will expire when employee benefits expire or when cancelled in writing.

2. Important Information About Your Rights

I have read and understood the following statements about my rights:

- I may revoke this authorization at any time prior to its expiration date by notifying the providing organization in writing, but the revocation will not have any affect on any actions the entity took before it received the revocation.
- I may see and copy the information described on this form if I asked for it.
- I am not required to sign this form to receive my health care benefits (enrollment, treatment, or payment).
- The information that is used or disclosed pursuant to this authorization may be re-disclosed by the receiving entity. I have the right to seek assurances from the above-named persons/organizations authorized to receive the information that they will not re-disclose the information to any other party without my further authorization.

3. Signature of Patient or Patient's Representative

	/ /
Signature of patient or patient's representative	Date
Printed name of the patient's personal representative	Relationship to the patient, including authority for status as representative

**** YOU MAY REFUSE TO SIGN THIS AUTHORIZATION, HOWEVER ANY CLAIMS WILL NOT BE ABLE TO BE PROCESSED ****