Member Health Statement/Enrollment Form

Group Coverage

Form to be completed by Applicant – Please print clearly and complete all questions.

A. CONSENT FOR USE OF PERSONAL INFORMATION (Does not apply to residents of the UK)

Enrollment under this group plan may require that you provide us with sensitive personal information about you and your enrolling dependents. In accordance with the privacy policy posted on our website, we will require your consent and the consent of those dependents you are applying for to process this request for insurance coverage.

Once enrolled, we will require your continued consent to administer your plan and this will include pre-authorization of medical services, claims administration, appeals, and plan renewal (if applicable).

Our privacy policy tells you about your privacy rights and how the law protects you. This includes information on how we collect and then process your personal information. Our privacy policy is located on our website at www.totalscholasticsolutions.com/privacy-policy and we would advise you to read the policy so you understand your rights and your personal data use by the TSS Group.

Your personal information, including special category or sensitive personal information such as medical and health details which you supply to the insurer may be used in many ways including, but not limited to: processing and underwriting your application for insurance, deciding whether an offer of insurance coverage can be made and on what terms, administering your policy and handling claims, and detecting and preventing fraudulent activity. Other TieCare affiliates and third parties who provide services to the insurer could use your information in the same manner and further detail in respect of the transfer of your data to third parties is contained in the privacy policy.

By ticking the box **"I CONSENT"**, you consent to the use and disclosure of your healthcare information in accordance with our privacy policy. If you do not consent to the use and disclosure of your healthcare information TieCare will not be able to evaluate your request and therefore will not be able to provide you with insurance cover. The following enrollment form should only be completed if you are willing to provide consent.

Primary Applicant Signature:	Printed Name:
☐ **I CONSENT**	Date:
Spouse Signature: (If dependent spouse applying for coverage)	Printed Name:
☐ **I CONSENT**	Date:
Child Signature: (Dependent children age 16 or older if applying for coverage)	Printed Name:
☐ **I CONSENT**	Date:

B. EMPLOYEE DETAILS

Last Name:	First Name:	Middle Initial:
Gender: ☐ Male ☐ Female	Marital Status: ☐ Single ☐ Married ☐ Domestic Partner ☐ Divorced ☐ Widowed	
Date of Birth (dd/mmm/yyyy):	Citizenship (If dual, provide both):	
Passport # or National Identity Card #:	Nationality (Place of Birth):	
Date of Departure for International Assignment:	Country of Residence While on Assignment:	Anticipated Length of Assignment:
Email Address:	Have you ever been covered by TieCare Group Before?: ☐ Yes ☐ No	
Employer Name:	Employer Address:	
Annual Salary (Specify Currency):	Occupation and Title (Please provide full description):	
Date of Hire (dd/mmm/yyyy):	Number of Hours Worked per Week:	Requested Effective Date (dd/mmm/yyyy):

DEPENDENT INFORMATION (Complete below only if enrolling dependents)

Relationship: **Spouse**	Last Name:	First Name:	Date of Birth (dd/mmm/yyyy):	Gender: ☐ Male ☐ Female	Height / Weight: m / feet:__________ kgs / lbs: _________
Spouse's Occupation:			Spouse's Country of Residence:		
Relationship: **Child**	Last Name:	First Name:	Date of Birth (dd/mmm/yyyy):	Gender: ☐ Male ☐ Female	Height / Weight: m / feet:__________ kgs / lbs: _________
Relationship: **Child**	Last Name:	First Name:	Date of Birth (dd/mmm/yyyy):	Gender: ☐ Male ☐ Female	Height / Weight: m / feet:__________ kgs / lbs: _________
Relationship: **Child**	Last Name:	First Name:	Date of Birth (dd/mmm/yyyy):	Gender: ☐ Male ☐ Female	Height / Weight: m / feet:__________ kgs / lbs: _________
Relationship:	Last Name:	First Name:	Date of Birth (dd/mmm/yyyy):	Gender: ☐ Male ☐ Female	Height / Weight: m / feet:__________ kgs / lbs: _________

TRAVEL PATTERN

Anticipated travel pattern for the next 12 months.

Destination	Frequency	Duration	Duties	Destination	Frequency

C. MEDICAL QUESTIONNAIRE (Complete for all members applying for coverage.)		
1) Have you or any dependents ever been diagnosed, tested, hospitalized or recommended for treatment for any of the following:		
1A) Seizures or any seizure disorders, paralysis, migraines, multiple sclerosis or any other neurological disorder?	☐ Yes	☐ No
1B) Any mental, behavioral or emotional disorders such as depression, anxiety, neurosis, psychosis, eating disorders, autism or need for any kind of psychotherapy?	☐ Yes	☐ No
1C) High blood pressure, high cholesterol or triglycerides, heart attack, aneurysm, stroke, chest pain or palpitations, blood clots or any other heart or circulatory disorders?	☐ Yes	☐ No
1D) Asthma, allergies, bronchitis, sinusitis or any lung or respiratory disorders?	☐ Yes	☐ No
1E) Hepatitis (or positive test for hepatitis), colitis, chronic diarrhea, hiatal hernia, esophagitis, ulcer of the stomach or duodenum, hemorrhoids, gall bladder problems, pancreatitis or any liver, pancreas or other digestive disorders?	☐ Yes	☐ No
1F) Cancer, benign tumors, cysts or enlarged lymph nodes?	☐ Yes	☐ No
1G) Psoriasis, dermatitis or any type of skin disorders?	☐ Yes	☐ No
1H) Anemia, hemophilia or any disorder of the blood?	☐ Yes	☐ No
1I) Kidney stones, bladder problems or any other kidney or urinary disorder?	☐ Yes	☐ No
1J) Breast, ovaries or uterus disorders, endometriosis, prostate conditions or elevated PSA, sexually transmitted diseases or any other disorder of the genital or reproductive system?	☐ Yes	☐ No
1K) Rheumatoid Arthritis or any kind of arthritis, rheumatism, lupus or any kind of auto-immune disorders; any disorders of the knees, shoulders, spinal column problems or any other joints, muscle or bones disorders?	☐ Yes	☐ No
1L) Diabetes, thyroid disorders, pituitary, adrenal or any other endocrinal conditions?	☐ Yes	☐ No
1M) Cataracts, glaucoma or any eye disorder, hearing loss or any ear, nose or throat disorder?	☐ Yes	☐ No
1N) Acquired Immune Deficiency Syndrome (AIDS), ARC (AIDS related complex), HIV positive or other immune disorders?	☐ Yes	☐ No
1O) Birth defects, genetic mutations, congenital or hereditary disorders or any malformations?	☐ Yes	☐ No
2) Female: Are you currently pregnant?	☐ Yes	☐ No
2A) Female: If currently pregnant, is this pregnancy a result of infertility treatment?	☐ Yes	☐ No
2B) Female: Is there a history of complications with previous pregnancies (such as eclampsia, premature births, etc.) or are complications anticipated with this pregnancy, if currently pregnant?	☐ Yes	☐ No
3) Has any applicant gained or lost more than 12 kg or 25 pounds in the last 12 months?	☐ Yes	☐ No
4) Is any applicant a candidate for or a recipient of any type of transplant?	☐ Yes	☐ No
5) Has any applicant been hospitalized in the past 10 years for any reason?	☐ Yes	☐ No
6) Has any applicant been declined, postponed, surcharged or limited for life, health or accident insurance?	☐ Yes	☐ No
7) Do you engage in any profession, sport, or hobby that could potentially be considered hazardous, or do you engage in any professional sport?	☐ Yes	☐ No
8) Has any applicant been advised to have a surgical procedure, hospitalization, or undergo testing that has not yet been completed; or awaiting the results of any tests?	☐ Yes	☐ No
9) Has any applicant had any symptom, health problem, injury or disorder not mentioned above, for which he has or has not consulted a medical practitioner?	☐ Yes	☐ No
10) Primary Applicant's Current Height:		☐ Ft ☐ cm
11) Primary Applicant's Current Weight:		☐ kg ☐ lb

MEDICAL QUESTIONNAIRE (Give details of each item answered "Yes" in Section B)

(If more space is needed, attach separate page, which must be signed and dated)

Name	Question No.	Condition/ Diagnosis	Treatment (Surgeries/ Medications)	Treatment Dates From/To	Ongoing or Date of Recovery	Name, Location or Telephone Number of Physician, Hospital/Institution

D. MEDICATION (List all medications that are currently prescribed for you or a family member.)
☐ **Check if you and your family members do not take any prescriptions.**

Member Name	Medication Name	Dosage	Frequency	Reason For Use

E. MEDICAL PRACTITIONER (Please provide details of your family Doctor, if you have one.)

Physician's Name:	Country:

F. REPRESENTATIONS, ACKNOWLEDGEMENTS, AND AUTHORIZATIONS

I, the Undersigned Hereby:

1. Declare that the foregoing answers to the best of my knowledge and belief are true and accurate and are offered as an inducement to grant insurance.
2. Declare that I am currently actively at work and mentally and physically capable of conducting the regular duties of my employment and have not been absent from work for more than 10 consecutive days in the preceding twelve months.
3. Agree that there shall be no insurance until the Insurer has approved this application.
4. Authorize any medical professional, hospital, clinic, other medical or medically related facility, governmental agency, or other person or firm to provide the Insurer or their authorized representative information, including copies of records, concerning advice, care, or treatment provided to me, including without limitation, information relating to mental illness or use of drugs or alcohol.
5. Understand that such information will be used by the Insurer for the purpose of evaluating my application for insurance, or by Insurer representatives involved in evaluating, determining, or administering claims for insurance benefits. I understand that any authorized representative or I will receive a copy of this authorization upon request.

Applicant Signature:	Date:

Fax the completed form to +949-457-3116 or Email to enroll@tiecare.com