# BUPA CORPORATE CARE MEMBER
# ENROLLMENT FORM FOR GROUP HEALTH INSURANCE

☐ Member enrollment ☐ Dependent addition Eligibility date:

## 1. GROUP INFORMATION

| Group Name | | Group ID | |
|---|---|---|---|

## 2. PERSONAL INFORMATION

Please provide information of all insureds to be included in this membership, as well as a copy of the ID document for each member.

| Name | Relationship to member | Marital status* | Date of birth | Sex | Weight ☐ Kg ☐ Lbs | Height ☐ M ☐ Feet |
|---|---|---|---|---|---|---|
| Last First M.I. | Self | | MM/DD/YY | M ☐ F ☐ | | |

| Citizenship | Country of birth | ID Type | Number |
|---|---|---|---|
| | | | |

| Name | Relationship to member | Marital status* | Date of birth | Sex | Weight | Height |
|---|---|---|---|---|---|---|
| Last First M.I. | | | MM/DD/YY | M ☐ F ☐ | ☐ Kg ☐ Lbs | ☐ M ☐ Pies |
| ID Type | | Number | | | | |
| Last First M.I. | | | MM/DD/YY | M ☐ F ☐ | ☐ Kg ☐ Lbs | ☐ M ☐ Pies |
| ID Type | | Number | | | | |
| Last First M.I. | | | MM/DD/YY | M ☐ F ☐ | ☐ Kg ☐ Lbs | ☐ M ☐ Pies |
| ID Type | | Number | | | | |
| Last First M.I. | | | MM/DD/YY | M ☐ F ☐ | ☐ Kg ☐ Lbs | ☐ M ☐ Pies |
| ID Type | | Number | | | | |

***S:** single **M:** married DP: domestic partner **D:** divorced **W:** widow(er)
If more space is required, please use additional sheet, signed and dated. If completed, please check here to confirm. ☐

If this form includes children **19 years of age or older**, are they college or universitiy full-time students? ☐ Yes ☐ No
If you answered "Yes", please provide a copy of a certificate or affidavit from the college or university as evidence of full-time student status.

## 3. GENERAL INFORMATION

| Home address | | | | | |
|---|---|---|---|---|---|
| City | | State | | Country | |
| Mailing address (if different from home address) | | | | | |
| City | | State | | Country | |
| Please send correspondence to: ☐ Home address ☐ Mailing address | | | | | |
| Home telephone number | | Work Telephone Number | | Cellular number | |
| E-mail | | | | | |

## 4. OTHER INSURANCE INFORMATION

Please list any other health insurance policies in effect or any applications in process with Bupa or any other company.

| Insurance company | |
|---|---|

## 5. ACKNOWLEDGEMENT AND AUTHORIZATION

I certify that I have read and reviewed all the answers and statements declared in this Member Enrollment Form for Group Health Insurance and that to the best of my ability, they are complete and truthful. I understand that any omissions, incorrect or incomplete statements could cause claims to be denied, and the policy to be modified, cancelled, or rescinded. If any member requires medical care or treatment after the Member Enrollment Form and Medical Supplement are signed, but before the effective date of this membership, I will provide full details to Bupa for final approval before coverage is effective. I agree to accept my membership in this Group Policy with the terms and conditions as issued. I hereby authorize the Group Administrator to receive my Membership Guide, Membership Certificate, and all documents related to my insurance coverage.

### Authorization to Collect Health Information

I hereby authorize Bupa Insurance Company and its Miami subsidiaries and affiliates (collectively "Bupa") to request my and/or my dependents' protected health information including, without limitation, my and/or my dependents' medical records, any prescription medication records/history, treatment records or plans, and any other medical or pharmaceutical information to be considered in the underwriting decision upon my and/or my dependents' application. I hereby authorize any physician, hospital, lab, pharmacy, or any other health care provider, health plan, employer/group policyholder or benefit plan administrator, the Medical Information Bureau (MIB), and any other organization or person, including any member of my family having access to any medical records or knowledge of myself or my health, to disclose such information to Bupa, its Business Associates, or its designated agents (collectively, "Bupa Entities").

The existence of any such information and documentation as described above shall be disclosed under this application. I understand that Bupa Entities will rely on such information to 1) underwrite this application for coverage and make eligibility, risk rating, policy issuance, and enrollment determinations for all of the applicants; 2) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 3) administer coverage, and 4) conduct other insurance operations according to applicable law.

I understand that Bupa's ability to underwrite the insurance is dependent upon the receipt of all necessary health information. As such, my refusal to provide authorization (marking "No" below) will result in the rejection of my application for enrollment.

☐ Yes ☐ No

### Authorization to Disclose Health Information

I hereby authorize Bupa Insurance Company and its Miami subsidiaries and affiliates (collectively "Bupa") to use and disclose my policy conditions, certificate of coverage, and other insurance documents, payment information, claims filings, and medical records which may contain protected health information, to the Group Administrator appointed for my Group. I understand that the Group Administrator's use and disclosure of my protected health information is limited through the Group Plan documents, as required by the Health Insurance Portability and Accountability Act (HIPAA).

☐ Yes ☐ No

I understand that:

• Bupa will use any information supplied in this application and received through this authorization prior to the effective date of coverage in considering my application. • Bupa will comply with the Health Insurance Portability and Accountability Act of 1996 as amended and supplemented and the regulations thereto (HIPAA) and that the use and disclosure of information will be done under the applicable HIPAA statute and rules. • I am entitled to receive a copy of this authorization. • A copy of this authorization shall be as valid as the original. • The authorization shall be valid for the complete term of the coverage, including automatic renewal. • This is a voluntary authorization, and that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipients and no longer protected under HIPAA. • I have the right to revoke this authorization by notifying Bupa in writing and subject to and in accordance with 45 C.F.R. §164.508. However, the revocation will not be effective until Bupa receives and processes such revocation. Revocations shall be sent by postal or electronic mail to:

Bupa Privacy Office: 17901 Old Cutler Road, Suite 400, Palmetto Bay, Florida 33157 USA
Privacyoffice@bupalatinamerica.com

I have reviewed and understand the content and purpose of this acknowledgement and authorizations. By signing or replying affirmatively, I am confirming that the authorization decisions noted above accurately reflect my wishes. My signature below constitutes acceptance of all items listed above.

| Member's signature | | Date | MM/DD/YY |
|---|---|---|---|
| Spouse's signature | | Date | MM/DD/YY |
| Authorized Representative signature | | Títle | |
| Authorized Representative name | | Date | MM/DD/YY |