DMBA

DECLARATION OF INSURABILITY

IMPORTANT NOTE: ANY BENEFITS RESULTING FROM THIS DECLARATION OF INSURABILITY WILL BE EFFECTIVE THE DATE DMBA DETERMINES THE EVIDENCE TO BE SATISFACTORY, SUBJECT TO THE PREEXISTING CONDITIONS PROVISION.

PERSONAL INFORMATION (REQUIRED)

Employee name: _____ DMBA ID number: _____

Employer name: _____ Department: _____ Hire date (MM/DD/YYYY): _____

Home address: _____ City: _____ State: _____ ZIP code: _____

EMPLOYEE AND DEPENDENT COVERAGE

Applicant Name (First, Middle, Last)	Relationship to Employee	Birth Date (MM/DD/YYYY)	Age	Height (Ft., In.)	Weight (Lbs.)	Weight One Year Ago	Occupation	In Good Health Now? Yes or No
EMPLOYEE	SELF							
	SPOUSE							

1. Is each person listed above now in good health? If not, give name(s)and details: _____

2. Has any company or association ever declined to grant insurance on any person listed above or offered a modified policy? If so, give reasons, name(s), dates, and name of the company:

3. Has any person listed above ever received disability compensation? If so, give reasons, name(s) and details: _____

4. Has any person listed above had employment or potential employment impacted by physical or mental health? If so, give name(s) and details:

FOR DMBA USE ONLY

☐ APPROVED ☐ HIGH RISK ☐ DECLINED EFFECTIVE DATE: _____ INITIALS: _____

DOES ANY PERSON LISTED HAVE (OR HAVE THEY HAD) ANY OF THE FOLLOWING? (CHECK "YES" OR "NO")

	Yes	No		Yes	No
1. Current prescription medication (list below name of drug, illness being treated, and duration)	☐	☐	12. Diabetes, blood-sugar problem	☐	☐
2. Surgical operations, hospitalization, serious accidents	☐	☐	13. Arthritis (state type), lupus, bone disease or infection	☐	☐
3. High or low blood pressure, artery or vein disorder, blood disorder	☐	☐	14. Stroke, epilepsy, seizures	☐	☐
4. Diagnosed with or treated for any heart disease or heart abnormality	☐	☐	15. Eye disease, hearing problem	☐	☐
5. Heart attack, heart surgery, a heart procedure, a pacemaker/defibrillator, or an abnormal heart rhythm	☐	☐	16. Cancer of any type, tumors, unexplained growths	☐	☐
6. Hospitalization for depression, mental illness, psychiatric care, any treatment for depression	☐	☐	17. Alcohol use (list below amount and duration of use)	☐	☐
7. Malaria, typhoid fevers, tuberculosis, spinal meningitis, venereal disease	☐	☐	18. Head or internal injuries	☐	☐
8. Stomach ulcers, disorders of the stomach or intestines, colon, rectal diseases	☐	☐	19. Physical disabilities, paralysis, congenital abnormalities, amputation, muscular disorders	☐	☐
9. Liver, kidney, ureter, gallbladder, pancreas, thyroid disorders, hepatitis	☐	☐	20. Respiratory or lung disease, asthma, shortness of breath, pneumonia	☐	☐
10. AIDS, AIDS-related complex, HIV positive, other immune deficiency disorders	☐	☐	21. High or low cholesterol/triglycerides	☐	☐
11. Smoke or use (have used) tobacco products (list below type, amount, and duration)	☐	☐	22. Disease or disorder not already identified	☐	☐
12. Ever used LSD, heroin, cocaine, marijuana or other such drugs	☐	☐			

IF YOU ANSWER "YES" TO ANY OF THE ITEMS LISTED, GIVE FULL DETAILS BELOW. ATTACH A SEPARATE SHEET OF PAPER IF NECESSARY.

Item #	Patient Name	Initial Date of Illness or Medication	Duration of Illness or Medication	Describe in Detail the Illness or Reason for Medication	Present Condition

AUTHORIZATION

I have carefully read all of the above questions, statements, and answers, and all such statements and answers are correct and true. I authorize the use of this questionnaire in connection with any benefit applied for in this application, and I understand any misstatement or omission in this application may void such benefit. I understand I may be contacted to undergo a medical exam, paid for by DMBA, in conjunction with benefits applied for in this application. I understand and agree that there will be no benefits in effect until DMBA approves the applicant(s). Coverage will be effective the first of the month following the month the applicant is approved. I authorize any licensed physician, hospital, pharmacy, clinic or other medical or medically related facility, laboratory, insurance company, or other organization, institution, or person who has any records or knowledge of me or my health (or of any persons proposed for benefits) to release information, including prescription drug records, maintained by physicians, pharmacy benefit managers, and other sources of information to DMBA for the purpose of evaluating my application. A photocopy of this authorization and request form shall be as valid as the original. In all circumstances, my authorized agent or representative or I may request a copy of this authorization. This authorization may be used for a period of six months from the date signed, unless sooner revoked. On behalf of me and my dependents, I waive any action for such disclosure.

Participant/Employee Signature: _____ Date: _____
SIGN AND DATE IN INK

Spouse Signature: _____ Date: _____
SIGN ONLY IF SPOUSE BENEFIT IS REQUESTED

Dependent Signature: _____ Date: _____
SIGN ONLY IF DEPENDENT CHILD BENEFIT IS REQUESTED AND CHILD IS AGE 18 OR OLDER

Please return this completed form to DMBA enrollmenthelp@dmba.com. You may also mail it to DMBA, Attention: Member Services, P.O. Box 45530, Salt Lake City, UT 84145-0530 or fax it to 801-578-5933. For questions, visit www.dmba.com or call us at 801-578-5600 or 800-777-3622.