ENROLLMENT FORM 2026

EMPLOYER INFORMATION

Employer Name	Group Number	Date of Hire	Effective Date
A-1 Personnel of Houston, Inc.	FCR8619		

EMPLOYEE INFORMATION

Last Name	First Name	Gender	Social Security #
		☐ Male ☐ Female	

Date of Birth	Client Assignment
	☐ City of Houston ☐ Harris County ☐_____

Address	City	State	Zip

Marital Status	Email Address	Phone Number	Reason for Enrollment
☐ Single ☐ Divorced ☐ Married ☐ Separated			☐ Open Enrollment ☐ New Hire ☐ Family Status

MEDICAL COVERAGE OPTIONS

Choose One Option Only

☐ Minimum Essential Coverage (MEC) Plan
☐ MEC Plus Value Plan
☐ MEC Plus Select Plan
☐ Minimum Value Plan (MVP) - (You must complete and return the IHQ form to enroll in the MVP)

Coverage Tier
☐ Employee
☐ Employee + Spouse
☐ Employee + Child(ren)
☐ Family

LIFE AND/OR AD&D INSURANCE BENEFICIARY DESIGNATION

Beneficiary Name	Date of Birth	Relationship

DEPENDENT INFORMATION

Last Name	First Name	Gender	Social Security #	Date of Birth
Spouse		☐ Male ☐ Female		
Dependent		☐ Male ☐ Female		
Dependent		☐ Male ☐ Female		
Dependent		☐ Male ☐ Female		

CURRENT/PRIOR COVERAGE

Have you or your dependents been covered under this employer's plan or any other major medical plan(s) at any time in the past 12 months? ☐ Yes ☐ No

If yes, who is covered? ☐ Employee ☐ Spouse ☐ Child(ren)	**Name of Carrier**	**Policy/ID#**	**Effective Date**
Will prior coverage remain active when coverage under this employer's plan goes into effect? ☐ Yes ☐ No			**If no, what is the term date?**

QUALIFIED MEDICAL CHILD SUPPORT ORDER

Are any of your dependents covered by a Qualified Medical Child Support Order? ☐ Yes ☐ No (if yes, complete below)

Custodial Parent	**Name of Dependent**	**Dependent's Social Security #**	**Dependent's Date of Birth**	
Dependent's Residential Address		**City**	**State**	**Zip**

EMPLOYEE AGREEMENT

I hereby apply for participation in my employer's Employee Health and Welfare Benefit Plan for myself and/or my dependents listed above and agree to abide by the terms, provisions, and limitations as outlined by the Plan Sponsor in the issuance of the Plan Summary Description. I declare all statements contained in this form are true and correct and that no material information has been withheld or omitted. I understand that any misstatements or failure to report information that is material to my qualification and participation may be used as a basis for rescission of my participation and/or denial of payment of claims. I agree no benefits will be effective until the date specified at the top of this form.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, the Veterans Administration, the Medical Information Bureau (MIB), or any other organization, institution, insurance or reinsurance company, to disclose and release any information in its possession about the medical history, mental or physical condition or treatments of myself and/or my dependents to Fringe Benefit Group or its designee. A photostatic copy of this authorization shall be considered as effective and valid as the original.

Signature	**Date**

Fringe Benefit Group - (866) 866-3424

MVP INDIVIDUAL HEALTH QUESTIONNAIRE ON NEXT PAGE

EMPLOYEE HEALTH QUESTIONNAIRE

ONLY FILL OUT THIS FORM IF YOU ARE ENROLLING IN THE MINIMUM VALUE PLAN (MVP).

Please print or type in dark ink. See enrollment guide for benefit details and explanation of your cost. Retain a copy of this application for your records.

Employer Name:_____
Address:_____

Employee Name: _____ Gender: M or F Birth Date:_____
Address: _____ City:_____
County:_____ State:_____ Zip:_____
Home or Cell Phone:_____ Work Phone:_____ E-mail Address:_____

Are you a US Citizen? □ Yes □ No
Marital Status: □ Single □ Married □ Divorced □ Separated
If "No", what is your status?:_____

Date of Full-time Employment:_____ Average Hours worked per week:_____
Job Duties:_____
Owner, Partner or Corporate Officer? □ Yes □ No
Employment Status: □ Active □ COBRA/Continuation □ Retired □ Disability □ Other Leave

Coverage Type: □ Self only □ Self and Spouse □ Self and Child(ren) □ Self, Spouse and Child(ren)
OR
I am Waiving coverage for: □ Myself □ Spouse □ Child(ren)
And the Reason for waiving is: □ Covered by another group/individual health plan or
□ Other_____

SPOUSE AND/OR DEPENDENTS TO BE COVERED (PLEASE INCLUDE ANOTHER PAGE TO LIST MORE DEPENDENTS)

Applicant Name(S)	Relationship to Employee	M or F	Date of Birth	Social Security #	Height/ Weight	Tobacco Use?
	Employee					
	Spouse					
	Child					
	Child					

Health Questions: Please answer the following, providing details to "YES" answers for all Applicants in the space indicated. If you need more space, please use a second form.

In the past (3) years, has any Applicant seen a doctor, been diagnosed with, had treatment, hospitalization, medications, tests, or been advised to have treatment or surgery for any of the following:

a.	Heart attack, brain tumor, stroke, heart disease or heart problems? Or Other not listed?	☐ Yes ☐ No	g.	Diabetes, endocrine or pituitary disorder, growth disorder, lupus, MS, AIDS, or HIV+? Or Other not listed?	☐ Yes ☐ No
b.	Cancer, tumor, lymphoma, or transplant? Or Other not listed?	☐ Yes ☐ No	h.	Alcoholism, drug, or any substance abuse? Or Other not listed?	☐ Yes ☐ No
c.	Emphysema, lung disorder, or COPD? Or Other not listed?	☐ Yes ☐ No	i.	Back or joint problems, rheumatoid arthritis, fibromyalgia, paralysis or any musculoskeletal condition? Or Other not listed?	☐ Yes ☐ No

d.	Brain disorder, bipolar, psychotic disorder, seizures, epilepsy, or any other mental or emotional condition? Or Other not listed?	☐ Yes ☐ No	j.	Currently pregnant, an expectant parent, premature delivery or multiple birth ? due date? _______________	☐ Yes ☐ No
e.	Kidney failure, dialysis, or disorder of the liver including hepatitis and cirrhosis, stomach, pancreas, colon or bladder? Or Other not listed?	☐ Yes ☐ No	k.	Any surgery, tests, drugs, doctor visit or hospitalization current, advised, planned or recommended?	☐ Yes ☐ No
f.	Hemophilia, blood disorder, anemia, circulatory disorder, or any blood or circulatory condition? Or Other not listed?	☐ Yes ☐ No	l.	Any Burns, or other medical condition(s) not listed in previous questions?, any disability?, or taking any prescription drugs?	☐ Yes ☐ No

Please provide FULL DETAILS to "YES" answers, including the name of the Applicant(s), condition(s), treatment(s), medication(s), and dates. If more space is needed, please attach a separate page with details, including the Applicant's name.

Question Letter:	Applicant Name:	Condition/Diagnosis/ Treatment/ Physician Name/ Contact Info:	Date of Onset and Recovery?	Surgery or Hospitalization? ☐ Yes ☐ No	Still Under Treatment? ☐ Yes ☐ No	Medication? ☐ Yes ☐ No Drug name?
Question Letter:	Applicant Name:	Condition/Diagnosis/ Treatment/ Physician Name/ Contact Info:	Date of Onset and Recovery?	Surgery or Hospitalization? ☐ Yes ☐ No	Still Under Treatment? ☐ Yes ☐ No	Medication? ☐ Yes ☐ No Drug name?
Question Letter:	Applicant Name:	Condition/Diagnosis/ Treatment/ Physician Name/ Contact Info:	Date of Onset and Recovery?	Surgery or Hospitalization? ☐ Yes ☐ No	Still Under Treatment? ☐ Yes ☐ No	Medication? ☐ Yes ☐ No Drug name?
Question Letter:	Applicant Name:	Condition/Diagnosis/ Treatment/ Physician Name/ Contact Info:	Date of Onset and Recovery?	Surgery or Hospitalization? ☐ Yes ☐ No	Still Under Treatment? ☐ Yes ☐ No	Medication? ☐ Yes ☐ No Drug name?

Authorization and Signature

My signature declares that the answers and medical information presented on this application are complete and accurate for all Applicants. I understand this information will be used as the basis for group underwriting. Any misrepresentations, misstatements or omissions of medical information that I make may result in revision of rates, or denial of my claims or my coverage. I understand that the following parties may need to review this information: Business Associates, re-insurers, and all persons authorized to represent these organizations for these purpose. I authorize any health care provider, hospital or medically related facility, pharmacy, or pharmacy related facility, consumer reporting agency, insurance or reinsurance company, having information about me or any of my Dependent Applicants to provide all such information as requested by the aforementioned.

I understand that this Authorization may be needed for the purpose of gathering information to determine underwriting and group rating and I have included all information regarding diagnosis, treatment, and prognosis or medical conditions including physical, mental, psychiatric, drug, alcohol, and prescription history. Unless revoked earlier, this Authorization will be valid for thirty (30) months after the date it is signed, and a photocopy of this authorization is as valid as the original. I understand that I can revoke this authorization at any time by giving written notice to the plan administrator.

Employee/Primary Applicant Signature:____ Date: __________________

SECURE EMAIL MESSAGE CENTER

SEND EMAILS SAFE AND SECURE TO THE AMERICAN WORKER

Security is much easier when it just works automatically; and that's exactly what the Secure Email Message Center offers. By automatically encrypting and decrypting messages and attachments, secure email is as easy as regular email for both senders and recipients.

THINGS TO KNOW

Emails and attachments are scanned automatically, removing extra work and eliminating stress about sensitive data going unprotected. If emails contain sensitive information, they are encrypted and delivered to the recipients, who must set up a password to open the message the first time. The next time the recipient receives an encrypted email, they will be asked to enter that same password.

- The Secure Email Message Center will deliver to any @theamericanworker (or other variations) email address.
- Sender may send attachments with a message size of up to 15 MB.
- The Secure Email Message Center will automatically recognize content that needs to be sent "secure". If the email is deemed secure, the recipient will receive a link to open the message center to retrieve and respond to an email. If the email does not contain sensitive information, the message will be delivered directly to their email program (Outlook, etc.).

YOU CAN ACCESS THE SECURE EMAIL MESSAGE CENTER DIRECTLY ON WWW.THEAMERICANWORKER.COM BY CLICKING ON THE "SECUREMAIL" LINK ON THE TOP.