ENROLLMENT APPLICATION

network health

Employer Name:	Date Hired/Rehired (circle one):
Employee Last Name: Legal First Name: Nickname: MI:	
Street Address/Apt. # :	Hours Worked Per Week:
City: State: Zip: County:	
Home Phone: Work Phone: Work Email:	Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed
Sex: ☐M ☐F	

If anyone named in this application is waiving/declining coverage, please complete the waiver section. If anyone named in this application is applying for coverage, please complete the enrollment section.

Applying For:	**Waiving/Declining Coverage For**:
☐ Myself ☐ My Spouse ☐ My Dependent Children	☐ Myself ☐ My Spouse ☐ My Dependent Children *Please complete the waiver section on page three*

ENROLLMENT SECTION (ATTACH ADDITIONAL PAPER IF NECESSARY)

	Name (Last, First, MI)	Birth date mm/dd/yr	Sex M/F	Ht.	Wt	Relationship	Dis-abled Y/N	Primary Care Practitioner first, last name	Established Patient? Y/N
Self	SSN#					Self			
Sp.	SSN#					Spouse			
Dep 1	SSN#					☐ Child ☐ Stepchild ☐ Grandchild ☐ Guardianship			
Dep 2	SSN #					☐ Child ☐ Stepchild ☐ Grandchild ☐ Guardianship			
Dep 3	SSN #					☐ Child ☐ Stepchild ☐ Grandchild ☐ Guardianship			

Do all of the dependents listed above reside at the same address as the employee: ☐Yes ☐No
If no, list dependent name and address: _____

Do you or any of your dependents have other group medical insurance including Medicare? ☐ Yes ☐ No
If yes, will this coverage continue concurrently with Network Health Plan? ☐ Yes ☐ No
If yes, who is the person who holds the other insurance policy and what is the relationship to the insured? _____
Does this other policy include pharmacy coverage? ☐ Yes ☐ No

List below who is covered under the other group medical insurance, policy number, name of insurance company, and effective date of coverage:

Name of Covered Individual(s)	Name of Insurance Company	Policy Number	Effective Date

Is there a divorce decree/court order establishing insurance responsibility? ☐ Yes ☐ No If yes, provide Network Health Plan with the portion of the decree which states responsibility.
Who is the responsible party? _____

Coded By	Underwriting	Approved By	DT Appr	Effective Date	Entered by	Date

FM-004-01-12/15

Employee Name:_____

REQUIRED MEDICAL INFORMATION

(Do not reveal results of any HIV or genetic testing that may have been done in reference to any of the following questions)

1. Are you or any eligible dependent disabled, hospital confined or pregnant? ☐ Yes ☐ No
   If disabled or hospitalized, date of occurrence: _____/_____/_____
   Cause of disability or hospitalization: _____
   If pregnant, due date: _____/_____/_____
   If pregnant, are you expecting a multiple birth, having complications or planning a C-section? ☐ Yes ☐ No

2. Have you or any eligible dependent used tobacco products in the last 12 months? ☐ Yes ☐ No

3. Have you or any eligible dependent been declined, postponed, ridered or rated up for medical, disability or life insurance with an insurance company? If yes, please explain. ☐ Yes ☐ No

   _____

4. In the past five years, have you or any eligible dependent to be covered received treatment, taken medication, received follow-up care, scheduled or are awaiting results of any tests, biopsies, procedures or lab work, been advised to have a test, had any symptoms, diagnosis or consultation or been advised of a condition that will require attention in the next 24 months? **If yes, check all which apply and give details below.** ☐ Yes ☐ No

☐ **A**. Acquired Immune Deficiency Syndrome (AIDS)/AIDS Related Complex (ARC)/HIV	☐ **K.** Lung/Respiratory Disorder/Asthma
☐ **B.** Alcohol/Drug/Psychological Disorder or Suicide Attempt	☐ **L.** Multiple Sclerosis
☐ **C.** Rheumatoid/Osteo/Psoriatic Arthritis	☐ **M.** Musculoskeletal/Back/Joint Disorders
☐ **D.** Brain/Seizure/Neurological Disorder or Migraines	☐ **N.** Organ/Tissue Disease or Transplant
☐ **E.** Cancer/Tumor	☐ **O.** Reproductive System Disorder/Infertility
☐ **F**. Crohn's Disease/Colitis	☐ **P**. Stroke
☐ **G.** Diabetes or Endocrine Disorders	☐ **Q**. Immune System Disorder
☐ **H.** Heart/Circulatory/Blood Disorders/Hypertension	☐ **R**. Birth Defect/Congenital Disorder
☐ **I.** Kidney Disorder	☐ **S**. Other Conditions Not Listed Above
☐ **J.** Liver Disorder/Hepatitis	☐ **T**. Currently Taking Any Medications?

In the spaces below, please provide details to questions for which you answered YES above. This includes information regarding last doctor visit and/or physical examination and all medications taken. If you need additional space, please attach a separate sheet of paper with signature and date.

Letter or Number	Family Member	Dates of Treatment	Identify the Medication, Condition, its Duration, Treatment and Degree of Recovery

Waiver Section

I hereby certify that I was informed of the availability of coverage under the policy. I have decided not to apply for coverage offered for (check those which apply): ☐ Self ☐ Spouse ☐ Dependent Children

If waiving coverage, please sign below. I understand that if I desire to apply for coverage at a later date I may be considered a Late Enrollee and subject to an 18-month waiting period. Notwithstanding this waiting period, I elect to decline the coverage because:

- ☐ My dependent(s) and/or I are already covered by a health benefit plan that provides similar or better coverage. **Please attach a copy of both sides of the identification card**.
- ☐ My dependent(s) and/or I are electing or have elected alternative coverage offered by my employer at this time of enrollment. **Please attach a copy of both sides of the identification card**.
- ☐ My dependent(s) and/or I do not wish insurance and are without significant health problems.
- ☐ My dependent(s) and/or I are not insured under a State mandatory risk sharing plan under chapter 619 of the Wisconsin statutes, and my premium contribution would be more than 10% of my annual earnings. **Please attach a copy of your W2 form.**

Signature (Copy/Fax valid as original)	Print Name	Date Signed

Confidentiality Statement

In completing this Application, I authorize any health care provider to release any of my medical information, including those records pertaining to the testing and treatment of mental health, alcohol and/or substance abuse, to Network Health Plan's medical and claims management personnel, when reasonably related to my application for coverage through Network Health Plan ("NHP"). By signing this authorization as the Employee or Spouse, you also authorize the release of medical information for any covered minor dependents and/or any covered dependents for which you have legal guardianship. This form does not permit the use or disclosure of psychotherapy notes or the disclosure of information concerning whether I, my spouse, or my dependent child(ren) have obtained a test for the presence of HIV antigen or non-antigenic products of HIV or an antibody to HIV or what the results of this test were.

I also authorize any health care provider to release any and all of my medical records, to NHP when reasonably related to coverage for quality measurement or administrative purposes. This authorization is valid while my coverage is in effect or for as long as a claim is pending, whichever is longer. I understand I am entitled to inspect and obtain a copy of the released records and that I may revoke these authorizations at any time except to the extent that a health care provider has already acted in reliance upon them. I also understand that I am, or my authorized representative is entitled to receive a copy of this complete form. By signing this form, I authorize NHP to release this information for a period not to exceed 30 months from the date this application is signed.

If any law or provider requires an additional authorization for the release of medical records, I will be required to sign a special consent for the release of this information. I understand that NHP will make every effort to protect my privacy at all times, and that member identifiable information will not be shared with my employer unless authorized by "me", the member.

I understand that failure to authorize the release of medical information to NHP may cause significant delays in the processing of my claims. I also understand that NHP retains the right to release claim information received from health care providers to NHP contracted entities to accomplish its obligations under the group contract.

All information furnished by me on this Application is true and complete to the best of my knowledge. Any person who presents or prepares any statement, document or claim, and the person knew or should have known the statement, document or claim contained materially false, incomplete or misleading information concerning the rating of an insurance policy or the application for the issuance of an insurance policy is guilty of insurance fraud. *WI Stat 895.486(1) (a) (e).*

Employee Signature	Date	Print Name

Nondiscrimination

Network Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Network Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Network Health:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact Jessica Vander Zanden at 800-826-0940.

If you believe that Network Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with Jessica Vander Zanden, Vice President of Compliance and Culture, 1570 Midway Place, Menasha, WI 54952, phone number 800-826-0940, TTY 800-947-3529, Fax 920-720-1907, compliance@networkhealth.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Jessica Vander Zanden, Vice President of Compliance and Culture is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

Multi-language Interpreter Services

If you, or someone you're helping, has questions about Network Health, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 800-826-0940.

Spanish: Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Network Health, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 800-826-0940.

Hmong: Yog koj, los yog tej tus neeg uas koj pab ntawd, muaj lus nug txog Network Health, koj muaj cai kom lawv muab cov ntshiab lus qhia uas tau muab sau ua koj hom lus pub dawb rau koj. Yog koj xav nrog ib tug neeg txhais lus tham, hu rau 800-826-0940.

Chinese: 如果您，或是您正在協助的對象，有關於[插入SBM項目的名稱 Network Health 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字800-826-0940.

German: Falls Sie oder jemand, dem Sie helfen, Fragen zum Network Health haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 800-826-0940 an.

Arabic:
إذا كان لديك أو لدى شخص كنت مساعدة، أسئلة حول Health Network، لديك الحق في الحصول على المساعدة والمعلومات باللغة الخاصة بك دون أي تكلفة. للتحدث مع مترجم فوري، قم باستدعاء 800-826-0940.

Russian: Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Network Health, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 800-826-0940.

Korean: 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Network Health 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는800-826-0940.로 전화하십시오.

Vietnamese: Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Network Health, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 800-826-0940.

Pennsylvania Dutch: "Wann du hoscht en Froog, odder ebber, wu du helfscht, hot en Froog baut Network Health, hoscht du es Recht fer Hilf un Information in deinre eegne Schprooch griege, un die Hilf koschtet nix. Wann du mit me Interpreter schwetze witt, kannscht du 800-826-0940 uffrufe.

Laotian: ຖ້າທ່ານ, ຫຼືຄົນທ່ທ່ານກໍາລັງຊ່ວຍເຫຼືອ, ມຄໍາຖາມກ່ຽວກັບ Network Health, ທ່ານມ ສິດທ່ ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທ່ເປັນພາສາຂອງທ່ານບ່ມ ຄ່າໃຊ້ຈ່າຍ. ການໂອ້ລົມກັບນາຍພາສາ, ໃຫ້ໂທຫາ 800-826-0940.

French: Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Network Health, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 800-826-0940.

Polish: Jeśli Ty lub osoba, której pomagasz ,macie pytania odnośnie Network Health, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku .Aby porozmawiać z tłumaczem, zadzwoń pod numer 800-826-0940.

Hindi: यदि आप**,** या किसी को आप की मदद कर रहे हैं**,** के बारे में सवाल है Network Health, आप कोई भी कीमत पर अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। एक दुभाषिया के लिए बात करने के लिए, 800-826-0940 कहते हैं।.

Albanian: Nëse ju, ose dikush që po ndihmoni, ka pyetje për Network Health, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin 800-826-0940.

Tagalog: Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Network Health, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 800-826-0940.