ASSURE SELF-INSURED ENROLLMENT APPLICATION

network health

Employer Name:		Plan Name:	
Employee Last Name	Legal First Name:	Nickname:	MI:
Street Address/Apt. #:			
City:	State:	Zip:	County:
Home Phone:	Work Phone:	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Gender ☐ M ☐ F
Email:	Date Hired Full-Time:	Average Hours Worked Per Week	

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: ☐ Myself ☐ My Spouse ☐ My Dependent Child(ren)	**Waiving/Declining Coverage For**: ☐ Myself ☐ My Spouse ☐ My Dependent Child(ren) *Please complete the waiver section on page four.*

ENROLLMENT SECTION (ATTACH ADDITIONAL PAPER IF NECESSARY)

Answering the race and ethnicity questions is your choice. You will not be denied coverage if the questions remain unanswered.

	Name (Last, First, MI)	Birth date (mm/dd/yy)	Gender	Ht.	Wt.	Disabled	Relationship
Self	SSN #		☐ M ☐ F			☐ Yes ☐ No	Self

Name of Personal Doctor (Strongly recommended): _____ Current patient? ☐ Yes ☐ No

What is your race? ☐ American Indian or Alaska Native ☐ Asian Indian ☐ Black or African American ☐ Chinese ☐ Filipino ☐ Guamanian or Chamorro ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Other Asian ☐ Other Pacific Islander ☐ Samoan ☐ Vietnamese ☐ White ☐ I choose not to answer

What is your ethnicity? ☐ Not Hispanic, Latino/a or Spanish ☐ Hispanic, Latino/a or Spanish ☐ Cuban ☐ Puerto Rican ☐ Mexican, Mexican American, Chicano/a ☐ I choose not to answer

	Name (Last, First, MI)	Birth date (mm/dd/yy)	Gender	Ht.	Wt.	Disabled	Relationship
Spouse	SSN #		☐ M ☐ F			☐ Yes ☐ No	Spouse

Name of Personal Doctor (Strongly recommended): _____ Current patient? ☐ Yes ☐ No

What is your race? ☐ American Indian or Alaska Native ☐ Asian Indian ☐ Black or African American ☐ Chinese ☐ Filipino ☐ Guamanian or Chamorro ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Other Asian ☐ Other Pacific Islander ☐ Samoan ☐ Vietnamese ☐ White ☐ I choose not to answer

What is your ethnicity? ☐ Not Hispanic, Latino/a or Spanish ☐ Hispanic, Latino/a or Spanish ☐ Cuban ☐ Puerto Rican ☐ Mexican, Mexican American, Chicano/a ☐ I choose not to answer

	Name (Last, First, MI)	Birth date (mm/dd/yy)	Gender	Ht.	Wt.	Disabled	Relationship
Dependent 1	SSN #		☐ M ☐ F			☐ Yes ☐ No	☐ Child ☐ Stepchild ☐ Guardianship

Name of Personal Doctor (Strongly recommended): _____ Current patient? ☐ Yes ☐ No

What is your race? ☐ American Indian or Alaska Native ☐ Asian Indian ☐ Black or African American ☐ Chinese ☐ Filipino ☐ Guamanian or Chamorro ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Other Asian ☐ Other Pacific Islander ☐ Samoan ☐ Vietnamese ☐ White ☐ I choose not to answer

What is your ethnicity? ☐ Not Hispanic, Latino/a or Spanish ☐ Hispanic, Latino/a or Spanish ☐ Cuban ☐ Puerto Rican ☐ Mexican, Mexican American, Chicano/a ☐ I choose not to answer

Employee Last Name: _____ Employee First Name: _____

	Name (Last, First, MI)	Birth date (mm/dd/yy)	Gender	Ht.	Wt.	Disabled	Relationship
Dependent 2	SSN #		☐ M ☐ F			☐ Yes ☐ No	☐ Child ☐ Stepchild ☐ Guardianship
	Name of Personal Doctor (Strongly recommended): _____ Current patient? ☐ Yes ☐ No						
	What is your race? ☐ American Indian or Alaska Native ☐ Asian Indian ☐ Black or African American ☐ Chinese ☐ Filipino ☐ Guamanian or Chamorro ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Other Asian ☐ Other Pacific Islander ☐ Samoan ☐ Vietnamese ☐ White ☐ I choose not to answer						
	What is your ethnicity? ☐ Not Hispanic, Latino/a or Spanish ☐ Hispanic, Latino/a or Spanish ☐ Cuban ☐ Puerto Rican ☐ Mexican, Mexican American, Chicano/a ☐ I choose not to answer						

	Name (Last, First, MI)	Birth date (mm/dd/yy)	Gender	Ht.	Wt.	Disabled	Relationship
Dependent 3	SSN #		☐ M ☐ F			☐ Yes ☐ No	☐ Child ☐ Stepchild ☐ Guardianship
	Name of Personal Doctor (Strongly recommended): _____ Current patient? ☐ Yes ☐ No						
	What is your race? ☐ American Indian or Alaska Native ☐ Asian Indian ☐ Black or African American ☐ Chinese ☐ Filipino ☐ Guamanian or Chamorro ☐ Japanese ☐ Korean ☐ Native Hawaiian ☐ Other Asian ☐ Other Pacific Islander ☐ Samoan ☐ Vietnamese ☐ White ☐ I choose not to answer						
	What is your ethnicity? ☐ Not Hispanic, Latino/a or Spanish ☐ Hispanic, Latino/a or Spanish ☐ Cuban ☐ Puerto Rican ☐ Mexican, Mexican American, Chicano/a ☐ I choose not to answer						

Do all 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 with the portion of the decree which states responsibility.
Who is the responsible party? _____

Preferred Language

Spoken: ☐ English ☐ Spanish ☐ Hmong ☐ German ☐ Chinese ☐ American Sign Language ☐ Other
Written: ☐ English ☐ Spanish ☐ Hmong ☐ German ☐ Chinese ☐ Other

Alternate Format

Select one if you want us to send you information in an alternate format or a language other than English.
☐ Large Print ☐ Braille ☐ Audio CD ☐ Language other than English (Language needed): _____

Employee Last Name: _____ Employee First Name: _____

REQUIRED MEDICAL INFORMATION

Your employer is establishing a self-insured employee benefit plan permitted under the Employee Retirement Income Security Act of 1974 (ERISA) and it is not an insured plan. You must answer all the questions below completely and truthfully. Where requested, you must provide additional information below. Failure to answer these questions completely and truthfully may result in loss of coverage for any or all persons included on this application.

1. Are you or any eligible dependent(s) disabled, hospital confined or pregnant? ☐ Yes ☐ No
   If disabled or hospitalized, date of occurrence: _____/_____/_____
   Cause of disability or hospitalization: _____
   If pregnant, due date: _____/_____/_____ ☐ Yes ☐ No
   If pregnant, are you expecting a multiple birth, having complications or planning a C-section?
2. Have you or any eligible dependent(s) used tobacco products in the last 12 months? ☐ Yes ☐ No
3. Have you or any eligible dependent(s) 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(s) 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? ☐ Yes ☐ No
   If yes, check all which apply and give details below.

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

Employee Last Name: _____ Employee First Name: _____

Waiver Section (Complete this section if you are waiving coverage for yourself and/or your dependent/s.)

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

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 not eligible for coverage until the next open enrollment period. I acknowledge this waiting period and 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.
- ☐ My dependent(s) and/or I are electing or have elected alternative coverage offered by my employer at this time of enrollment.
- ☐ 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 percent of my annual earnings.

If you are declining enrollment for yourself or your dependent(s) because of other health insurance, you may be able to enroll in this plan if you lose eligibility for the other coverage. Enrollment must be requested within 30 days after the other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. Enrollment must be requested within 30 days after the marriage, birth, adoption, or placement for adoption.

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

Employee Agreement / Authorization to Release Medical Information For Enrollment - SIGNATURE REQUIRED

I understand that the previous answers will be relied upon by the Plan Sponsor in the issuance of a Summary Plan Description. **I declare all statements contained in this entire form about me and my dependents are true and correct to the best of my knowledge and that no material information has been withheld or omitted. I understand that my intentional misrepresentation of a material fact in this application may be used as the basis to rescind, terminate or modify coverage for me or my dependents. Rescind means that the coverage was never in effect.** I agree that no coverage will be effective until the date specified by the Plan Sponsor in the Summary Plan Description. If I am now waiving medical benefits for myself and/or my dependents, I have read the entire Waiver provision, and understand the enrollment requirements if I make request for such benefits at a later date. I authorize my employer to deduct the necessary contribution toward the benefits. I reserve the right to revoke this deduction authorization at any time upon my written notice. Benefits are effective only after approval by the Plan Sponsor or Administrator and satisfaction of any probationary period. Any person who knowingly and with intent to defraud, submits an application or files a claim containing any materially false information may be found guilty of fraud, which is a crime, in a court of law and may be subject to fines and confinement in prison.

I hereby authorize those physicians, medical practitioners, hospital, clinics, veteran's administration facilities, medical information services, urgent care facilities, and other medical or medically related entities, insurance or reinsurance companies, and consumer reporting agencies that have information available concerning my present or former physical health condition, including drug or alcohol abuse, and/or treatment of me to release any and all such information, including, but not limited to, medical records, health care provider notes, laboratory tests and results, diagnoses, treatment, and prognoses. I understand the information obtained by use of this authorization are to be used for underwriting and risk rating determinations for my employer's self-insured health plan. This authorization is not applicable to psychotherapy notes. I agree that a photographic copy of this authorization shall be as valid as the original and that this authorization shall be valid for 2 ½ years from the date shown below. I understand that I may request a copy of this authorization. I understand that I may revoke this authorization at any time in writing unless action has been taken in reliance on my authorization. Should I refuse to sign this authorization, I understand it may affect my enrollment (and my dependents' enrollment) in the benefit plan. All pages must be attached and complete, including this authorization for the application to be considered complete. Incomplete applications may be rejected. If an additional authorization for the release of my (or my dependents') medical records is necessary, I (or my dependents) will be required to sign an authorization for the release of this information prior to enrollment in the plan.

The information on this application is valid for a maximum of 90 days from the date of the signature.

If signed by a representative, please indicate the representative's authority to act on behalf of employee:

Employee Signature	Date	Print Name