ASSURE SELF-INSURED ENROLLMENT APPLICATION

network health

Employer 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

Sex: ☐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 Children

Waiving/Declining Coverage For:
☐ 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 ☐ Guardianship			
Dep 2	SSN #					☐ Child ☐ Stepchild ☐ Guardianship			
Dep 3	SSN #					☐ Child ☐ Stepchild ☐ 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 coverage (including Medicare)? ☐ Yes ☐ No
If yes, will this coverage continue concurrently with this coverage? ☐ Yes ☐ No
If yes, who is the person who holds the other coverage and what is the relationship to the employee? _____
Does this other coverage include pharmacy coverage? ☐ Yes ☐ No

List who is covered under the other group medical coverage, policy number, name of insurance company or group name 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? _____

Employee 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 of 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 of the persons included on this application.

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 (or the pregnant eligible dependent) 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.** 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/Intestinal/Digestive Disorder	☐ **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, its Duration, Treatment and Degree of Recovery

Waiver Section

Please complete this section if you are waiving coverage for yourself and/or your dependents.

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 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 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 dependents 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

Plans administered by Network Health Administrative Services, LLC. and Stop Loss Insurance Underwritten by Network Health Insurance Corporation.