

# ASSURE SELF-INSURED APPLICATION and CHANGE FORM



Name of Employer:	Date of Full-Time Employment:
Group #/Class:	Effective Date/Date of Change:

Coverage	Reason for Application/Change		
<input type="checkbox"/> EPO	<input type="checkbox"/> New Subscriber	<input type="checkbox"/> Address Change	
<input type="checkbox"/> HMO	<input type="checkbox"/> Add Dependent	<input type="checkbox"/> Benefit Plan Change	Dependent addition reason:
<input type="checkbox"/> POS	<input type="checkbox"/> Termination	<input type="checkbox"/> COBRA/Continuation	Termination reason:
<input type="checkbox"/> Network Options	<input type="checkbox"/> Dependent Termination	<input type="checkbox"/> Open Enrollment	Dependent termination reason:
<input type="checkbox"/> Other	<input type="checkbox"/> Name Change	<input type="checkbox"/> Waiver of Insurance	Other:

Employee Information				
Last Name:	Legal First Name:	Nickname:	MI:	<b>Status (check)</b>
Address/Apt. #:				<input type="checkbox"/> Single <input type="checkbox"/> Married
City:	State:	Zip:	Email:	
Home Phone:		Work Phone:		

Enrollment Section (attach additional sheets of paper if necessary)							
	Name (Last, First, MI)	Birth Date MM/DD/YY	Sex	Disabled	Relationship	Primary Care Practitioner Name (Strongly recommended)	Current Patient?
<b>Self</b>	SSN # _____		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	Self		<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Sp.</b>	SSN # _____		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	Spouse		<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Dep 1</b>	SSN # _____		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Child <input type="checkbox"/> Stepchild		<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Dep 2</b>	SSN # _____		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Child <input type="checkbox"/> Stepchild		<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Dep 3</b>	SSN # _____		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Child <input type="checkbox"/> Stepchild		<input type="checkbox"/> Yes <input type="checkbox"/> No

**Network Health Plan (NHP) and/or Network Health Insurance Corporation (NHIC), as applicable, requires all legal paperwork for insuring dependents involving guardianship and adoption.**

Other Insurance Coverage Information	
Do you or any dependents have other group medical insurance including Medicare?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, does this other policy include pharmacy coverage?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Will this insurance continue after Network Health Plan begins?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Individuals who have other coverage:	Policyholder:
Name of insurance company:	Policy #:
Is there a divorce decree establishing insurance responsibility?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Name of responsible party:	Birth Date:
<b>Please provide Network Health Plan with a copy of the portion of the decree which states this responsibility.</b>	

**Confidentiality Statement**

I understand that the answers provided here within will be relied upon by the Plan Sponsor for administrative purposes and, if applicable, 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 form 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. 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 which may result then in loss of coverage under the plan. 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/change form 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 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 or change request (and my dependents' enrollment or change request) in the benefit plan. All pages must be attached and complete, including this authorization for this form to be considered complete.

If this form is incomplete, it 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.

**Employee signature is not required in a cancellation due to termination, but must be signed by the employer.**

Employee Signature	Date	Employer Signature	Date
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**Network Health Plan and/or Network Health Insurance Corporation Internal Use Only:**

Effective Date	Entered By	Date
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*Plans administered by Network Health Administrative Services, LLC. And Stop Loss Insurance Underwritten by Network Health Insurance Corporation.*

**Email this completed / signed form to:** [nhcommercialenrollment@networkhealth.com](mailto:nhcommercialenrollment@networkhealth.com)

**Or fax: 920-720-1904**

**Or mail to: Network Health  
1570 Midway Pl.  
Menasha, WI 54952**

## 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 Network Health's discrimination complaints coordinator at 844-300-5537.

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 Network Health's discrimination complaints coordinator, 1570 Midway Place, Menasha, WI 54952, phone number 844-300-5537, TTY 800-947-3529, Fax 920-720-1907, [compliance@networkhealth.com](mailto:compliance@networkhealth.com). You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Network Health's discrimination complaints coordinator 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 844-300-5537.

**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 844-300-5537.

**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 844-300-5537.

**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844-300-5537]。

**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 844-300-5537 an.

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 844-300-5537.

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 844-300-5537.

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 위해서는 844-300-5537.로 전화하십시오.

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 844-300-5537.

“Wann du hoscht en Froog, odder ebber, wu du helpscht, 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 844-300-5537 uffrufe.

ຖ້າທ່ານ, ຫຼືຄົນທີ່ທ່ານກຳລັງຊ່ວຍເຫຼືອ, ມາຖາມກ່ຽວກັບ Network Health, ທ່ານມີສິດທິຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ການໂອ້ນລັກກັບນາຍພາສາ, ໃຫ້ໂທຫາ 844-300-5537.

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 844-300-5537.

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 844-300-5537.

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, 844-300-5537 कहते हैं।

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 844-300-5537.

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 844-300-5537.