Agent Name: Agent Number:

1570 Midway Place / Menasha, WI 54952
Fax: 920-720-1904
nhcommercialenrollment@networkhealth.com

Individual ACA Enrollment and Change Form

Member ID #: _____ Effective date/Date of change*: _____

Benefit Plan Selection: _____ Quoted Monthly Premium: $ _____

Applying For:
☐ Myself ☐ My Spouse ☐ My Dependent Children

Reason for Application/Special Enrollment (*documentation required on all special elections*)

☐ New Subscriber	☐ Address Change	Dependent addition reason:
☐ Add Dependent	☐ Benefit Plan Change	Termination reason:
☐ Termination	☐ Other	Dependent termination reason:
☐ Dependent Termination		Addition/change explanation:
☐ Name Change		

Applicant Information

Last Name: Legal First Name: MI: **Status (check)** ☐ Single ☐ Married

Mailing Address/Apt. # :

City: State: Zip: County:

Home Address/Apt. #:

City: State: Zip: County:

Home Phone: Work Phone:

Email Address:

Enrollment Section (attach additional sheets of paper if necessary)

	Name (Last, First, MI) / SSN #	Birth date mm/dd/yr	Sex	Disabled	Relationship	Tobacco Use in Past Six Months**	Primary Care Practitioner Name (Strongly recommended)	Current Patient?
Self	SSN #		☐ M ☐ F	☐ Yes ☐ No	Self ☐	☐ Yes ☐ No		☐ Yes ☐ No
Sp.	SSN #		☐ M ☐ F	☐ Yes ☐ No	Spouse ☐	☐ Yes ☐ No		☐ Yes ☐ No
Dep 1	SSN #		☐ M ☐ F	☐ Yes ☐ No	☐ Child ☐ Stepchild ☐ Grandchild ☐ Guardianship	☐ Yes ☐ No		☐ Yes ☐ No
Dep 2	SSN #		☐ M ☐ F	☐ Yes ☐ No	☐ Child ☐ Stepchild ☐ Grandchild ☐ Guardianship	☐ Yes ☐ No		☐ Yes ☐ No
Dep 3	SSN #		☐ M ☐ F	☐ Yes ☐ No	☐ Child ☐ Stepchild ☐ Grandchild ☐ Guardianship	☐ Yes ☐ No		☐ Yes ☐ No

Other Insurance Information

Do you or any dependents have other group medical insurance including Medicare: ☐ Yes ☐ No

If Yes, does the other policy include pharmacy coverage? ☐ Yes ☐ No

Will the other insurance continue after Network Health Plan begins? ☐ Yes ☐ No

Individuals who have other coverage: Policyholder:

Name of other insurance company: Policy #:

Is there a divorce decree establishing insurance responsibility? ☐ Yes ☐ No

Name of responsible party: _____ Date of birth: _____

Please provide Network Health Plan with a copy of the portion of the decree which states this responsibility.

What is your primary language spoken at home? (Optional)

☐ English ☐ Spanish ☐ Chinese (Mandarin) ☐ German ☐ French ☐ Hindi ☐ Japanese ☐ Korean ☐ Italian ☐ Russian ☐ Arabic

☐ Thai ☐ Vietnamese ☐ Punjabi ☐ Other

What is your ethnic origin? (Optional)

☐ Asian ☐ Black or African-American ☐ Hispanic ☐ American Indian or Alaska Native ☐ Native Hawaiian or other Pacific Islander

☐ White/Caucasian ☐ Multi-ethnic ☐ Other

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, and HIV infection, to Network Health Plan medical and claims management personnel, when reasonably related to my coverage through Network Health Plan. (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.)

I also authorize any health care provider to release any and all of my medical records to Network Health Plan 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 Network Health Plan 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 Network Health Plan will make every effort to protect my privacy at all times.

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

All information furnished by me on this application is true and complete to the best of my knowledge.

Applicant Signature_____ Date_____

Network Health Plan (NHP) requires all legal paperwork for insuring dependents involving guardianship and adoption.

Visit *networkhealth.com* for an online Provider Directory to choose a primary care practitioner for yourself and dependents.

***Effective date of coverage is determined by ACA guidelines**
****In the last six months, have you used tobacco four or more times a week?**

Payment Options

There are several options you may choose to make your initial and future premium payments.

- Check/Money Order
- Automatic withdrawal from a bank account
- Credit card

Your initial premium payment is needed as part of your application process. You can make your initial premium payment in the following ways.

- Online (as part of your application process)
- Call Network Health at 855-275-1400
- Mail a check or money order to:

  Network Health
  Box 78870
  Milwaukee, WI 53278-8870

Please note, your coverage will not be active until the first premium payment has been received.
If you are a current member and would like to set up recurring payments you may do so online. You may set up recurring premium payments and make a one-time premium payment online.
https://networkhealth.com/individual/index.php

- Click **Member Sign In**
- Select **Individual (I buy insurance on my own)**
- Select **Pay my bill**
- Click **Log-In**

If you need assistance logging in contact Network Health at 855-275-1400.
If you would like Network Health to set up the recurring payment for you without use of the online payment system, please complete the information on either the Automatic Withdrawal Authorization Form or call Network Health's Accounts Receivable department at 877-549-8792 (select option 3) for assistance with credit card processing.

Automatic Withdrawal Authorization Form

By signing below, I authorize Network Health to initiate premium deductions (and corrections to premium deductions) from the bank account indicated, and the designated financial institution to debit the same account. I understand that the initial premium amount may vary as a result of enrollment review processes and that the following premium amounts may vary as a result of change(s) I make once enrolled. I understand that Network Health's rights with each premium deduction are the same as if I submit a check signed by me. This authorization is in effect until I provide Network Health with 30-day written notice that I no longer desire this service, and Network Health and the designated financial institution have the right to discontinue the premium deductions if they wish to do so. I also understand that a service charge may be incurred for any withdrawal not honored. This authorization will remain in effect until I notify Network Health in writing of its termination. My notification must afford Network Health and my financial institution a reasonable opportunity to process the notification.

ACCOUNT HOLDER INFORMATION

Name _____
Address _____
City _____ State _____ Zip Code _____

FINANCIAL INSTITUTION INFORMATION

Institution Name _____
Select One: ☐ Checking ☐ Savings
Transit Routing Number _____ Account Number _____

Note: Recurring payments through your banking institution or ACH withdrawals will pull on the seventh of each month for the following month's premium payment, for example, on October 7 the November premium payment will process. If the seventh is a weekend or a holiday, it will then pull the next business day.

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 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 Network Health's discrimination complaints coordinator, 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, 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 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 . 800-826-0940
دون أي تكلفة. للتحدث مع مترجم فوري، قم باستدعاء

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.