

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)**

|  |  |                               |
|--|--|-------------------------------|
| <input type="checkbox"/> New Subscriber        | <input type="checkbox"/> Address Change      | Dependent addition reason:    |
| <input type="checkbox"/> Add Dependent         | <input type="checkbox"/> Benefit Plan Change | Termination reason:           |
| <input type="checkbox"/> Termination           | <input type="checkbox"/> Other               | Dependent termination reason: |
| <input type="checkbox"/> Dependent Termination |  | Addition/change explanation:  |
| <input type="checkbox"/> Name Change           |  |                               |

**Applicant Information**

|                          |        |                   |         |     |                                 |                                  |
|--------------------------|--------|-------------------|---------|-----|---------------------------------|----------------------------------|
| Last Name:               |        | Legal First Name: |         | MI: | <b>Status (check)</b>           |                                  |
| Mailing Address/Apt. # : |        |                   |         |     | <input type="checkbox"/> Single | <input type="checkbox"/> Married |
| 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) | Birth date mm/dd/yr | Sex                        | Disabled                     | Relationship   | Tobacco Use in Past Six Months** | Primary Care Practitioner Name (Strongly recommended) | Current Patient?             |
|------------------------|---------------------|----------------------------|------------------------------|--|----------------------------------|---|------------------------------|
| <b>Self</b>            |                     | <input type="checkbox"/> M | <input type="checkbox"/> Yes | Self   | <input type="checkbox"/> Yes     |   | <input type="checkbox"/> Yes |
|                        | SSN #               | <input type="checkbox"/> F | <input type="checkbox"/> No  |  | <input type="checkbox"/> No      |   | <input type="checkbox"/> No  |
| <b>Sp.</b>             |                     | <input type="checkbox"/> M | <input type="checkbox"/> Yes | Spouse   | <input type="checkbox"/> Yes     |   | <input type="checkbox"/> Yes |
|                        | SSN #               | <input type="checkbox"/> F | <input type="checkbox"/> No  |  | <input type="checkbox"/> No      |   | <input type="checkbox"/> No  |
| <b>Dep 1</b>           |                     | <input type="checkbox"/> M | <input type="checkbox"/> Yes | <input type="checkbox"/> Child<br><input type="checkbox"/> Stepchild<br><input type="checkbox"/> Grandchild<br><input type="checkbox"/> Guardianship | <input type="checkbox"/> Yes     |   | <input type="checkbox"/> Yes |
|                        | SSN #               | <input type="checkbox"/> F | <input type="checkbox"/> No  |  | <input type="checkbox"/> No      |   | <input type="checkbox"/> No  |
| <b>Dep 2</b>           |                     | <input type="checkbox"/> M | <input type="checkbox"/> Yes | <input type="checkbox"/> Child<br><input type="checkbox"/> Stepchild<br><input type="checkbox"/> Grandchild<br><input type="checkbox"/> Guardianship | <input type="checkbox"/> Yes     |   | <input type="checkbox"/> Yes |
|                        | SSN #               | <input type="checkbox"/> F | <input type="checkbox"/> No  |  | <input type="checkbox"/> No      |   | <input type="checkbox"/> No  |
| <b>Dep 3</b>           |                     | <input type="checkbox"/> M | <input type="checkbox"/> Yes | <input type="checkbox"/> Child<br><input type="checkbox"/> Stepchild<br><input type="checkbox"/> Grandchild<br><input type="checkbox"/> Guardianship | <input type="checkbox"/> Yes     |   | <input type="checkbox"/> Yes |
|                        | SSN #               | <input type="checkbox"/> F | <input type="checkbox"/> No  |  | <input type="checkbox"/> No      |   | <input type="checkbox"/> No  |

**Other Insurance Information**

|   |  |
|---|--|
| Do you or any dependents have other group medical insurance including Medicare: | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If Yes, does the other policy include pharmacy coverage?                        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Will the other insurance continue after Network Health Plan begins?             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Individuals who have other coverage:  | Policyholder:  |
| Name of other insurance company:  | Policy #:  |
| Is there a divorce decree establishing insurance responsibility?                | <input type="checkbox"/> Yes <input type="checkbox"/> 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](http://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.