Membership Application and Change Form

Plan Name:	
Name of Employer:	Date of Full-Time Employment:
Group # /Rate Code:	Effective Date/Date of Change:

Coverage	Reason for Application/Change		
☐ HMO	☐ New Subscriber	☐ Address Change	**Give addition/change explanations here:**
☐ POS	☐ Add Dependent(s)	☐ Benefit Plan Change	Dependent(s) addition reason:
☐ Network Options	☐ Termination	☐ COBRA/Continuation	Termination reason:
☐ Other	☐ Dependent(s) Termination	☐ Open Enrollment	Dependent(s) termination reason:
	☐ Name Change	☐ Waiver of Insurance	Other:

Enrollment Section (attach additional sheets of paper if necessary)

Last Name:	Legal First Name:	Nickname:	MI:	Status (check)
Address/Apt #:				☐ Single ☐ Married
City:	State:	Zip:		☐ Hourly ☐ Salary
Home Phone:		Work Phone:		☐ Union ☐ Non-Union

Enrollment Section (attach additional sheets of paper if necessary)

Answering the race and ethnicity questions is your choice. You can't be denied coverage because you don't fill them out.

	Name (Last, First, MI)	Birth date mm/dd/yy	Gender	Disabled	Relationship	Name of Personal Doctor (Strongly recommended)	Current patient?
Self	 SSN #		☐ Male ☐ Female	☐ Yes ☐ No	Self		☐ 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	Disabled	Relationship	Name of Personal Doctor (Strongly recommended)	Current patient?
Spouse	 SSN #		☐ Male ☐ Female	☐ Yes ☐ No	Spouse		☐ 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	Disabled	Relationship	Name of Personal Doctor (Strongly recommended)	Current patient?
Dependent 1	 SSN #		☐ Male ☐ Female	☐ Yes ☐ No	☐ Child ☐ Stepchild ☐ Grandchild ☐ Guardianship		☐ 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

Enrollee Last Name: ______________________________ Enrollee First Name: ______________________________

	Name (Last, First, MI)	Birth date mm/dd/yy	Gender	Disabled	Relationship	Name of Personal Doctor (Strongly recommended)	Current patient?
Dependent 2	 SSN #		☐ Male ☐ Female	☐ Yes ☐ No	☐ Child ☐ Stepchild ☐ Grandchild ☐ Guardianship		☐ 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	Disabled	Relationship	Name of Personal Doctor (Strongly recommended)	Current patient?
Dependent 3	 SSN #		☐ Male ☐ Female	☐ Yes ☐ No	☐ Child ☐ Stepchild ☐ Grandchild ☐ Guardianship		☐ 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						

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): ________________________

Network Health Plan (NHP) and/or Network Health Insurance Corporation (NHIC), as applicable, 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.

Other Insurance Coverage Information

Do you or any dependents have other group medical insurance (including Medicare)? ☐ Yes ☐ No

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

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

Individuals who have other coverage: Policyholder:

Name of 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.

Enrollee Last Name: ______________________________ Enrollee First Name: ______________________________

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 and/or Network Health Insurance Corporation's medical and claims management personnel, when reasonably related to my application for coverage through NHP and/or NHIC, as applicable. (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 NHP and/or NHIC, as applicable, 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 NHP and/or NHIC, as applicable, 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 NHP and/or NHIC, as applicable, will make every effort to protect my privacy at all times, and that member-identifiable information will not be shared with my employer unless authorized by "me", the member.

I understand that failure to authorize the release of medical information to NHP and/or NHIC, as applicable, may cause significant delays in the processing of my claims. I also understand that NHP and/or NHIC retain(s) the right to release claim information received from health care providers to NHP and/or NHIC, as applicable, contracted entities to accomplish its obligations under the group contract.

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

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

Employee Signature	Date	Employer Signature	Date

Network Health Plan and/or Network Health Insurance Corporation Internal Use Only:

Effective Date	Entered By	Date

HMO and POS plans underwritten by Network Health Plan.

Fax this completed / signed form to: 920-720-1904