1570 Midway Place
PO Box 120
Menasha, WI 54952

ENROLLMENT APPLICATION
(51-99 Eligible & At Least 35 Enrolled Employees)

Employer Name: | Date Hired/Rehired (circle one):

Employee Last Name: | Legal First Name: | Nickname: | MI:

Street Address/Apt. # : | Hours Worked Per Week:

City: | State: | Zip: | County:

Home Phone: | Work Phone: | Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed | Sex: ☐M ☐F

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

ENROLLMENT SECTION (ATTACH ADDITIONAL PAPER IF NECESSARY)

	Name (Last, First, MI)	Birth date m/d/yr	Sex M/F	Ht.	Wt	Relationship	Dis-abled Y/N	Primary Care Practitioner (Required for processing HMO, POS) first, last name	PCP ID#	Established Patient? Y/N
Self	SSN#					Self				
Sp.	SSN#					Spouse				
Dep 1	SSN#					☐ Child ☐ Stepchild ☐ Grandchild ☐ Guardianship				
Dep 2	SSN #					☐ Child ☐ Stepchild ☐ Grandchild ☐ Guardianship				
Dep 3	SSN #					☐ Child ☐ Stepchild ☐ Grandchild ☐ Guardianship				

List any dependents stated above who will NOT be enrolling: ____

Do all of the dependents listed above reside at the same address as the employee: ☐Yes ☐No

If no, list dependent name and address: ____

Are any of the above dependents age 19 or over full-time students? ☐Yes ☐No If Yes, indicate name, school, and status:

Name	School	Status	
		☐ Part Time	☐ Full Time
		☐ Part Time	☐ Full Time

Have you or your dependents ever been a member of Network Health Plan? ☐ Yes ☐ No *If previously insured under a different name, list that name* ____

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

If yes, will this coverage continue concurrently with Network Health Plan? ☐ Yes ☐ No

If yes, who is the person who holds the other insurance policy and what is the relationship to the insured? _____________

Does this other policy include pharmacy coverage? ☐ Yes ☐ No

List below who is covered under the other group medical insurance, policy number, name of insurance company, 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 Plan with the portion of the decree which states responsibility.

Who is the responsible party? ___________________________________

Coded By	Underwriting	Approved By	DT Appr	Effective Date	Entered by	Date

Employee Name:___________________________________

Medical Information

Do not reveal the results of any HIV or genetic testing that may have been done in reference to any of the following questions.

1. Are you or any dependent disabled or unable to perform normal activities? ☐ Yes ☐ No
   If yes: Name: ______________________ Reason: ____
   Date of occurrence: __________________________
2. Are you or any dependent now pregnant or an expectant parent? ☐ Yes ☐ No
   If yes: Name: ______________________ Due date:_______________________________________
   List any complications:____
3. Are you or any dependent scheduled for an upcoming surgery? ☐ Yes ☐ No
   If yes, identify name(s), condition(s), date(s), and details in the space below.
4. Has anyone named in this application been hospitalized or had claims in excess of $10,000 within the last 24 months? **If yes, give details below**. ☐ Yes ☐ No
5. Within the last 24 months has anyone named in this application been treated by a doctor or other practitioner or been diagnosed with any of the following? ☐ Yes ☐ No

   If "yes", check all which apply and give details below.

☐ **A**. AIDS/AIDS Related Complex (ARC)	☐ **K.** Lung/Respiratory Disorder
☐ **B.** Alcohol/Drug/Psychological Disorder	☐ **L.** Multiple Sclerosis
☐ **C.** Rheumatoid/Osteo/Psoriatic Arthritis	☐ **M.** Musculoskeletal Disorders
☐ **D.** Brain/Seizure Disorder	☐ **N.** Organ Disease/Transplant
☐ **E.** Cancer/Tumor	☐ **O.** Reproductive System Disorder
☐ **F**. Crohn's Disease/Colitis	☐ **P**. Stroke
☐ **G.** Endocrine Disorders including Diabetes	☐ **Q**. Other Conditions Not Listed Above
☐ **H.** Heart/Circulatory/Blood Disorders	☐ **R**. Currently Taking Any Medications?
☐ **I.** Kidney Disorder	☐ **S.** None of the above
☐ **J.** Liver Disorder	

In the spaces below, please list medications and provide full details to all questions for which you answered YES above. If you need additional space, please attach a separate sheet of paper.

Letter or Number	Family Member	Dates of Treatment	Identify the medication, condition, its duration, treatment, and degree of recovery

Waiver Section

I hereby certify that I was informed of the availability of coverage under the policy. 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 subject to an 18-month waiting period. Notwithstanding this waiting period, I 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. **Please attach a copy of both sides of the identification card**.
- ☐ My dependent(s) and/or I are electing or have elected alternative coverage offered by my employer at this time of enrollment. **Please attach a copy of both sides of the identification card**.
- ☐ 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% of my annual earnings. **Please attach a copy of your W2 form.**

Signature (Copy/Fax valid as original)	Print Name	Date Signed

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, to Network Health Plan's medical and claims management personnel, when reasonably related to my application for coverage through Network Health Plan ("NHP"). 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. This form does not permit the use or disclosure of psychotherapy notes or the disclosure of information concerning whether I, my spouse, or my dependent child(ren) have obtained a test for the presence of HIV antigen or non-antigenic products of HIV or an antibody to HIV or what the results of this test were.

I also authorize any health care provider to release any and all of my medical records, to NHP 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 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 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 may cause significant delays in the processing of my claims. I also understand that NHP retains the right to release claim information received from health care providers to NHP 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. Any person who presents or prepares any statement, document or claim, and the person knew or should have known the statement, document or claim contained materially false, incomplete or misleading information concerning the rating of an insurance policy or the application for the issuance of an insurance policy is guilty of insurance fraud. *WI Stat 895.486(1) (a) (e).*

Employee Signature	Date	Print Name