ENROLLMENT APPLICATION

network health

Plan Name:			
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: Work Email:		Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Gender: ☐ 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 Child(ren)	**Waiving/Declining Coverage For**: ☐ Myself ☐ My Spouse ☐ My Dependent Children *Please complete the waiver section on page four*

ENROLLMENT SECTION (ATTACH ADDITIONAL 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	Ht.	Wt.	Disabled	Relationship
Self	SSN #		☐ M ☐ F			☐ Yes ☐ No	Self

Name of Personal Doctor (Strongly recommended): _____ Current patient? ☐ 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	Ht.	Wt.	Disabled	Relationship
Spouse	SSN #		☐ M ☐ F			☐ Yes ☐ No	Spouse

Name of Personal Doctor (Strongly recommended): _____ Current patient? ☐ 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	Ht.	Wt.	Disabled	Relationship
Dependent 1	SSN #		☐ M ☐ F			☐ Yes ☐ No	☐ Child ☐ Stepchild ☐ Grandchild ☐ Guardianship

Name of Personal Doctor (Strongly recommended): _____ Current patient? ☐ 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

Employee Last Name: _____ Employee First Name: _____

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

Do all of the dependents listed above reside at the same address as the employee: ☐ Yes ☐ No
If no, list dependent name and address: _____
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 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

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): _____

Employee Last Name: _____ Employee First Name: _____

REQUIRED MEDICAL INFORMATION

(Do not reveal 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 eligible dependent(s) disabled, hospital confined or pregnant? ☐ Yes ☐ No
   If disabled or hospitalized, date of occurrence: _____/_____/_____
   Cause of disability or hospitalization: _____
   If pregnant, due date: _____/_____/_____
   If pregnant, are you expecting a multiple birth, having complications or planning a C-section? ☐ Yes ☐ No
2. Have you or any eligible dependent(s) used tobacco products in the last 12 months? ☐ Yes ☐ No
3. Have you or any eligible dependent(s) been declined, postponed, ridered or rated up for medical, disability or life insurance with an insurance company? If yes, please explain. ☐ Yes ☐ No
   _____
4. In the past five years, have you or any eligible dependent to be covered received treatment, taken medication, received follow-up care, scheduled or are awaiting results of any tests, biopsies, procedures or lab work, been advised to have a test, had any symptoms, diagnosis or consultation or been advised of a condition that will require attention in the next 24 months? ☐ Yes ☐ No
   If yes, check all which apply and give details below.

- ☐ **A**. Acquired Immune Deficiency Syndrome (AIDS)/AIDS Related Complex (ARC)/HIV
- ☐ **B**. Alcohol/Drug/Psychological Disorder or Suicide Attempt
- ☐ **C**. Birth Defect/Congenital Disorder
- ☐ **D**. Brain/Seizure/Neurological Disorder or Migraines
- ☐ **E**. Cancer/Tumor
- ☐ **F**. Crohn's Disease/Colitis
- ☐ **G**. Diabetes or Endocrine Disorders
- ☐ **H**. Heart/Circulatory/Blood Disorders/Hypertension
- ☐ **I**. Immune System Disorder
- ☐ **J**. Kidney Disorder
- ☐ **K**. Liver Disorder/Hepatitis
- ☐ **L**. Lung/Respiratory Disorder/Asthma
- ☐ **M**. Multiple Sclerosis
- ☐ **N**. Musculoskeletal/Back/Joint Disorders
- ☐ **O**. Organ/Tissue Disease or Transplant
- ☐ **P**. Reproductive System Disorder/Infertility
- ☐ **Q**. Rheumatoid/Osteo/Psoriatic Arthritis
- ☐ **R**. Stroke
- ☐ **S**. Other Conditions Not Listed Above
- ☐ **T**. Currently Taking Any Medications?

In the spaces below, please provide details to questions for which you answered YES above. This includes information regarding last doctor visit and/or physical examination and all medications taken. If you need additional space, please attach a separate sheet of paper with signature and date.

Letter or Number	Family Member	Dates of Treatment	Identify the Medication, Condition, Duration, Treatment and Degree of Recovery

Employee Last Name: _____ Employee First Name: _____

Waiver Section

Please complete this section if you are waiving coverage for yourself and/or your dependent(s).

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 Child(ren)

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