Employee Group Enrollment Application

Instructions: Please complete all applicable areas of this application. Please print using black ink. Aspirus Health Plan, Inc. ("Aspirus" or "Insurer") or Third-Party Administrator ("TPA") does NOT guarantee approval of this application for any person, or issuance of a policy. When complete, please mail or email this application to the address shown on Page 5.

Section 1 – Employer Information *(to be filled out by employer)*

Employer Name			
Group Number	Subgroup	Class	Department

Section 2 – Employee Information

First Name	Middle Initial	Last Name		
Mailing Address		Apartment/Suite Number	Social Security Number	
City		State	Zip Code	
Daytime Phone Number	Email Address		Date of Birth	
Gender ☐ Male ☐ Female	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Employee Start Date	Hours Worked Per Week	Height/Weight

Race or ethnicity

☐ Caucasian/White ☐ African American/Black ☐ Alaskan
☐ American Indian or Native ☐ Asian ☐ Hispanic or Latino
☐ Native Hawaiian or Pacific Islander ☐ Southeast Asian
☐ Two or more races ☐ Other _____

What primary language is spoken in your home?

☐ English ☐ Albanian ☐ Arabic ☐ Chinese ☐ French ☐ German
☐ Hmong ☐ Korean ☐ Laotian ☐ Pennsylvania Dutch ☐ Polish
☐ Russian ☐ Spanish ☐ Tagalog ☐ Vietnamese
☐ Other _____

Section 3 – Reason for Application

☐ New Employee ☐ New Group Enrollee

☐ New Enrollee due to Annual Open Enrollment (**application must be received prior to the policyholder's anniversary date**)

☐ Special Enrollment due to: **Please provide the date of the qualifying event** _____

- ☐ Involuntary loss of Minimum Essential Coverage for any reason other than fraud, intentional misrepresentation of a material fact or failure to pay premium
- ☐ Marriage
- ☐ Birth
- ☐ Adoption or placement for adoption or appointment of legal guardianship
- ☐ Other _____

☐ COBRA—Reason _____ Start Date _____ Termination Date _____

☐ Add Dependent(s)

☐ Changing _____ to _____ Effective Date _____

☐ Change Benefit Plan—Current _____ Change to _____

☐ Change Network Option—Current _____ Change to _____

☐ Deleting Coverage (Explain) _____

☐ Other—Please indicate _____

Section 4 – Type of Health Coverage Requested

Type of Coverage	Applying For	Waiving/Declining Coverage For
☐ _____ ☐ _____ ☐ _____ ☐ _____ ☐ _____ ☐ _____	☐ Myself ☐ My Spouse ☐ My Dependents	☐ Myself ☐ My Spouse ☐ My Dependents

Section 5 – Applicant Enrollment Information

Please complete the following for all family members who are applying for coverage. If additional space is needed, please attach a separate sheet with completed information.

Dependent Name		Sex	Social Security Number	Relationship to Applicant	Height	Weight	Date of Birth
First	MI	☐ Male ☐ Female					
Last							
First	MI	☐ Male ☐ Female					
Last							
First	MI	☐ Male ☐ Female					
Last							
First	MI	☐ Male ☐ Female					
Last							
First	MI	☐ Male ☐ Female					
Last							

Section 6A – Medical Information

1. **Total Disability.** Is anyone named in this application now disabled or unable to perform normal work- or age-related activities? ☐ Yes ☐ No
   If yes, please identify names, conditions, dates of disability, and name and address of attending physician.

2. Within the past six months, has anyone named in this application who is age 21 or over used tobacco regularly (four or more times per week on average)? ☐ Yes ☐ No
   If yes, please list which applicants: _____

Section 6B – Medical Information—Health Questionnaire

DO NOT COMPLETE THIS SECTION IF YOU ARE ENROLLING AS A NEW HIRE OR LATE ENROLLEE INTO AN EXISTING PLAN. If you are enrolling for coverage(s) as part of a new group, please fill out the appropriate subsection below according to the number of employees enrolled in the group plan. Please note: you are required to forward to the Insurer or TPA any changes and/or dependents in your or any family member's health history that occur prior to your receipt of our written underwriting decisions on this application.

1. **Groups 250+ Enrolled Employees**
   Is anyone named on this application being considered for, on a list for, or scheduled for a transplant? ☐ Yes ☐ No

2. **Groups with 26 to 249 Enrolled Employees**
   a. Within the last 24 months, has anyone named in this application consulted, received treatment, had medication prescribed by a doctor, psychiatrist, psychologist, or other practitioner, or been diagnosed for: (a) cancer, (b) stroke, (c) diabetes, (d) heart or vascular disease, (e) multiple sclerosis, (f) muscular or systemic disease (such as arthritis or lupus), (g) transplant, (h) liver, kidney, lung, or intestinal disorder (except genetic testing results), (i) blood disorder, or (j) Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)? (AIDS tests received at anonymous counseling and testing sites or through home test kits need not be revealed. We are not seeking the results of HIV antibody Test.) ☐ Yes ☐ No
   b. Are you or any dependent (even if not listed on application) pregnant or been advised in the last 12 months that hospitalization, surgery, or treatment is needed or pending? ☐ Yes ☐ No (If yes, expected due date is: _____)
   c. Are you or any dependent named in this application currently taking any prescribed medications? ☐ Yes ☐ No

3. **Groups with 2 to 25 Enrolled Employees**
   a. Are you or any other dependent (even if not listed on application) currently pregnant? ☐ Yes ☐ No
   (If yes, expected due date is: _____)
   b. Is anyone named in this application currently taking any medications recommended or prescribed by a physician or other health care practitioner? ☐ Yes ☐ No
   c. Has anyone named in this application had medication recommended or prescribed by a physician or other health care practitioner within the past 12 months? ☐ Yes ☐ No
   d. Has anyone named in this application had a professional diagnosis of Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)? (AIDS tests received at anonymous counseling and testing sites or through home test kits need not be revealed. *We are not seeking the results of HIV Antibody Test*.) ☐ Yes ☐ No
   e. Within the last five years, has anyone named in this application been hospitalized or scheduled for hospitalization; had surgery or surgery scheduled; had a test or test scheduled; or been recommended to have a test or surgery that was not performed for any reason not already mentioned? ☐ Yes ☐ No
   f. Within the last five years, has anyone named in this application been counseled, consulted, or treated for any of the following conditions: (1) heart disease or disorder; (2) stroke; (3) circulatory disorder; (4) high blood pressure; (5) diabetes; (6) connective tissue disorder; (7) allergies; (8) asthma; (9) emphysema; (10) sinus; (11) nasal or lung disease or disorder; (12) ulcers; (13) stomach or intestinal disorder; (14) thyroid disorder; (15) adrenal disorder; (16) enlargement of the lymph nodes; (17) menstrual or gynecological disorder; (18) infertility; (19) sexual dysfunction; (20) arthritis; (21) back, joint, or muscle disorder; (22) ear, skin, or eye disorder; (23) cancer; (24) tumor; (25) abnormal growth; (26) nervous system disorder (including attention deficit and psychological disorders and multiple sclerosis); (27) headaches; (28) seizures; (29) epilepsy;(30) hepatitis; (31) liver disorder; (32) kidney, bladder, or prostate disorder; (33) hernia; (34) rectal disorder; (35) anemia; (36) blood disorder; (37) the use of alcohol, chemicals, or drugs (been advised to cease or decrease use of); or (38) transplant.
   ☐ Yes ☐ No If yes, please indicate which conditions using the corresponding numbers from above:

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

Question Number	Family Member	Treatment Date	Identify the medication, condition, its duration, treatment, and degree of recovery	Name/Address of Attending Physician

Section 7 – Information Regarding Other Health Coverage and Medicare

Does any person applying for coverage currently have other individual or group health coverage? ☐ Yes ☐ No
If yes, please provide coverage information below. If additional space is needed, please attach a separate sheet with completed information.

Policyholder Information	Name, Address, and Phone Number of Insurance Company/Plan Type	Policy Number	Type of Coverage	Effective Date of Coverage
Name _____ ☐ Employee ☐ Spouse Date of Birth _____			☐ Single ☐ Family	
			☐ COBRA	COBRA Effective Date _____ COBRA Termination Date _____
Name _____ ☐ Employee ☐ Spouse Date of Birth _____			☐ Single ☐ Family	
			☐ COBRA	COBRA Effective Date _____ COBRA Termination Date _____

Are you or any of your family members eligible for Medicare? ☐ Yes ☐ No
If yes, please complete the following or attach a copy of your Medicare card.

Name of person covered by Medicare	Medicare Card Number

Is Medicare eligibility due to: ☐ Over age 65 ☐ End-Stage Renal Disease (ESRD) ☐ Total Disability

Effective Dates: Part A _____ Part B _____ Part C (Medicare Advantage) _____ Part D _____

Section 8 – Health Coverage Waiver

If anyone named on this application is waiving or declining any coverage, please provide his/her name and check the reason he/she is waiving/declining:

Name(s) of person(s) waiving/declining _____

☐ I am covered or will be covered under another plan that is not sponsored by my employer.
☐ My dependents are covered or will be covered under another plan that is not sponsored by my employer.

☐ Other _____

Waiver: I certify that I have been given the opportunity to apply for group coverage and decline to enroll as indicated on behalf of me and/or my dependents. I understand that by signing this waiver, I and/or my dependents forfeit the right to coverage.

I understand that if I am declining enrollment for myself or my dependents (including my spouse) because of other health coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that I request enrollment within 31 days after my coverage ends. In addition, if I have a new dependent as a result of marriage, birth, adoption or placement for adoption, I understand that I may be able to enroll myself and my dependents provided that I request enrollment within 31 days after the marriage, birth or adoption. I further understand that, other than these qualifying events, if this form is submitted after the enrollment period, I cannot enroll until the next annual enrollment period if applicable.

Signature of Employee *(required if waiving coverage)* _____ Print Name _____ Date _____

Section 9 – Notice of Special Enrollment Rights for Health Coverage

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose coverage (or if the employer stopped contributing toward you or your dependent's other coverage).

Loss of coverage events include, but are not limited to: (a) the person no longer lives, resides, or works within his or her HMO service area, the HMO does not provide coverage for that reason, and there is no other coverage under the plan for the individual; (b) a dependent loses dependent status because he or she attains a particular age; (c) the plan no longer offers any benefits to a class of similarly situated individuals (such as if the plan terminates coverage for all part-time workers); and (d) a benefit package option terminates or the issuer stops operating in the group market.

However, you must request enrollment within 31 days (or 60 days for Medicaid eligibility, birth, or adoption of a child) after you or your dependent's other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and other dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

This notice is for informational purposes only and is informing you of your special enrollment rights.

Section 10 – Terms and Conditions

I hereby enroll for coverage under the insurance coverage(s) for which I am presently eligible, or for which I may become eligible. I understand and agree that the information obtained by using this Application will be used by Insurer or TPA to determine eligibility for benefits. I, on behalf of myself, my spouse, and my dependent child(ren), if any, named herein, agree to cooperate in providing Insurer or TPA with information needed to process this Application.

If any payroll deductions are required for this coverage, I authorize such deductions from my earnings. I reserve the right to revoke this deduction authorization at any time upon written notice to the employer.

An Application should not be submitted more than 45 days prior to the effective date. This document will become a part of the insurance contract when coverage is approved and issued.

I acknowledge that I have read and completed the entire Application. If I received assistance in reading or completing this Application, I have identified in the space provided below the person(s) who provided me with such assistance. I additionally agree that Insurer or TPA is not liable for any statement, representation, or other information provided to me, my spouse, or my dependent child(ren) that is not expressly contained in a written document provided by Insurer or TPA and signed by an authorized officer of the insurer or TPA. I agree that no insurance will be effective until the date specified by the company on the policy after this application has been accepted. I also understand that if I decline any coverage, future changes in coverage are NOT automatic and may be subject to Insurer or TPA's approval.

Name of Person Providing Assistance *(if applicable)* _____

Section 11 – Acknowledgment and Signatures

I acknowledge that:

- This application becomes part of my Medical Coverage Agreement.
- The signatures shown below allow me, my spouse/domestic partner to release to Insurer or TPA information about any person listed on my Individual and Family plan application documents.
- Under the Health Insurance Portability and Accountability Act (HIPAA), Insurer or TPA, without my authorization, may only release limited information about my selection of a plan to my spouse/domestic partner, adult/minor children, producer, or anyone else.
- Insurer or TPA may collect, use, or disclose the nonpublic personal information of persons listed on this application as required or permitted by law and to conduct routine business functions such as determining eligibility for enrollment, reviewing prior coverage for waiting periods, paying claims, and, if appropriate, coordinating benefits, and fulfilling other legal obligations specified in my Medical Coverage Agreement.
- I have read and agree to the Terms and Conditions (Section 10) included with this application.

I declare that, to the best of my knowledge, all information I have provided with this application is true and complete, and that all of the persons for whom I am requesting enrollment are eligible for coverage. I understand that if I have made intentionally false or misleading statements on behalf of myself or any family members, the Medical Coverage Agreement may be canceled retroactively to its effective date. I further understand that it is a crime to knowingly provide false, incomplete, or misleading information for the purpose of fraudulently obtaining health coverage. Penalties may include imprisonment, fines, and denial of benefits.

☐ **Documentation:** I am enclosing all documentation as required, including, if applicable, documentation to enroll due to a special qualifying event. Any missing information may delay processing of my application.

For more information on Special Enrollment Period requirements, please visit our website: aspirushealthplan.com.

☐ **Signature:** This application has been signed by me and my spouse/domestic partner, if applicable.

☐ If not the primary applicant, I am the:
- ☐ Parent
- ☐ Holder of Power of Attorney (attach legal documentation)
- ☐ Legal Guardian (attach legal documentation)

_____ _____
Primary applicant/(parent/legal guardian) signature Date

_____ _____
Spouse/domestic partner/dependent signature *(if applicable)* Date

Contact Information

[**Email to:** Enrollment@aspirushealthplan.com
Mail to: Aspirus Health Plan, Inc., Attn: Enrollment, P.O. Box 1062, Minneapolis, MN 55440
Call: 866-631-5404 or **Visit:** aspirushealthplan.com]

Nondiscrimination & Language Access Policy

Aspirus Health Plan, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. *We* do not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

We will:
Provide 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)

Provide 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 *us* at the phone number shown on the inside cover of this *contract*, *your* id card, or aspirushealthplan.com.

If *you* believe that *we* have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, *you* can file a grievance with:

Nondiscrimination Grievance Coordinator
Aspirus Health Plan, Inc.
PO Box 1062
Minneapolis, MN 55440
Phone: 1.866.631.5404 (TTY: 711)
Fax: 763.847.4010
Email: customerservice@aspirushealthplan.com

You can file a grievance in person or by mail, fax, or email. If *you* need help filing a grievance, the Nondiscrimination Grievance 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, D.C. 20201
1.800.368.1019, 800.537.7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language Assistance Services

Albanian: KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë.Telefononi në 1.866.631.5404 (TTY: 711).

Arabic: تنبيه: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك مجاناً . اتصل بن اعلى رقم الهاتف 1.866.631.5404(رقم هاتف الصم والبك : 711)

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelezle 1.866.631.5404 (ATS : 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zurVerfügung. Rufnummer: 1.866.631.5404 (TTY: 711).

Hindi: _यान द_: य_द आप ि हंदी बोलते ह_ तो आपके ि लए मु_त म_ भाषा सहायता सेवाएं उपल_ध ह_। 1.866.631.5404 (TTY: 711) पर कॉल कर_।

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1.866.631.5404 (TTY: 711).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1.866.631.5404 (TTY: 711)번으로 전화해 주십시오.

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1.866.631.5404 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.Звоните 1.866.631.5404 (телетайп: 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.866.631.5404 (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nangwalang bayad. Tumawag sa 1.866.631.5404 (TTY: 711)

Traditional Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請 致電 1.866.631.5404 (TTY:711).

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1.866.631.5404 (TTY: 711).

Pennsylvania Dutch: Wann du Deitsch (Pennsylvania German / Dutch) schwetzscht, kannscht du mitaus Koschte ebbergricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1.866.631.5404 (TTY: 711).

Lao: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ,ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1.866.631.5404 (TTY:711).