ASPIRUS HEALTH PLAN

Individual Special Enrollment Application

When to Apply

- You may be eligible to enroll in an Aspirus Health Plan individual plan outside the open enrollment period if you experience a special enrollment event. You must elect coverage timely. The timeframe for electing coverage varies with the type of event, but is generally no later than 60 calendar days after the date on which the event occurs. Refer to section III. Additional information is available at AspirusHealthPlan.com.

How to Apply

- Complete all sections of the application thoroughly and accurately, including signatures for all adults and dependents age 18 and older. Applications with missing or inaccurate information will be returned for completion, which may delay the effective date of your coverage.
- You can apply online at AspirusHealthPlan.com. Applying online may reduce processing time.

How to Submit Application

- Your application cannot be processed without the initial month's premium payment.
- Mail the completed application including additional documentation or written proof required to Aspirus Health Plan, Individual Product Department, PO BOX 1062, Minneapolis, MN, 55440, or fax it to (715) 257-6163.
- Aspirus Health Plan will deposit or debit your initial month's premium payment upon issuance of coverage.
- This application will become a part of your contract. Make a copy of the completed application for your own records.

Effective Date of Coverage

- The coverage effective date depends on the type of special enrollment event. Refer to section III.
- Do not cancel any existing coverage until we issue your policy and you accept it.

Additional Information

- To be eligible for coverage, you must be a Wisconsin resident in the county of Adams, Clark, Columbia, Florence, Forest, Iron, Juneau, Langlade, Lincoln, Marathon, Marquette, Oneida, Portage, Price, Sauk, Shawano, Taylor, Vilas, Waushara and Wood.
- This policy does not include pediatric dental services. Pediatric dental coverage is an essential health benefit that can be purchased as a stand-alone plan through the marketplace at HealthCare.gov. Please contact your broker or HealthCare.gov (1-800-318-2596).
- You may qualify for financial assistance to pay your monthly premium or reduce your health care out-of-pocket costs. To see if you qualify, visit HealthCare.gov.
- If you had a past due premium amount from prior coverage with us within the last twelve (12) months, we may reject your enrollment if you do not pay the past due amount along with your first month of premium.

Contact Us

- Please contact the Aspirus Health Plan Individual Product Department at 1-866-631-4611 if you have questions or need assistance completing your application.

ASPIRUS HEALTH PLAN

Individual Special Enrollment Application
P.O. Box 1062
Minneapolis, MN 55440
1.866.631.4611

AGENT INFORMATION

Agent Name

OFFICE USE ONLY
Application ID# _____

I. APPLICANT INFORMATION

❑ I am a new applicant. ❑ I am currently an Aspirus Health Plan member, adding a dependent. Current Member ID: _____

❑ I am currently an Aspirus Health Plan member and I want to enroll in a different plan. Current Member ID: _____

PRIMARY APPLICANT *(If you are applying on behalf of a minor, indicate their name here)*

First Name	Middle initial	Last name

PARENT/GUARDIAN *(Only if applying on behalf of a minor)*

First Name	Middle initial	Last name

APPLICANT'S HOME ADDRESS *(Enter street address/apartment number)*

Street

City	State	Zip Code	County

APPLICANT'S BILLING ADDRESS *(if different than home address)*

Street

City	State	Zip Code

MAILING PREFERENCE

Please send all mail (other than billing statements) such as my welcome kit, ID cards and claims information to:

❑ Home address ❑ Billing address ❑ Other mailing address: _____

MARITAL STATUS	PREFERRED TELEPHONE NUMBER	ALTERNATIVE TELEPHONE NUMBER
❑ Single ❑ Married		

EMAIL ADDRESS

PRIMARY APPLICANT

First Name	Middle initial	Last name	Birth date (mm/dd/yy)	Tobacco user[1]
				❑ Yes ❑ No

PRIMARY APPLICANT'S SOCIAL SECURITY NUMBER[2]	PRIMARY CARE PROVIDER (PCP)	MEDICARE STATUS	SEX
		❑ Covered ❑ Eligible ❑ None	❑ Male ❑ Female

OPTIONAL *(Fill in all that apply)*

RACE/ETHNICITY: ❑ White ❑ Black or African American ❑ Asian ❑ American Indian or Alaska Native ❑ Native Hawaiian or Other Pacific Islander ❑ Other Race ❑ Two or More Races

HISPANIC/LATINO: ❑ Yes ❑ No

PREFERRED LANGUAGE: ❑ English ❑ Spanish ❑ Hmong ❑ Albanian ❑ Vietnamese ❑ Chinese ❑ Russian ❑ Laotian ❑ Pennsylvania Dutch ❑ Karen ❑ German ❑ Arabic ❑ Polish ❑ French ❑ Korean ❑ Tagalog ❑ Other: _____

II. COMPLETE THIS SECTION FOR EACH PERSON, OTHER THAN THE PRIMARY SUBSCRIBER

DEPENDENT ONE

First Name	Middle initial	Last name	Birth date (mm/dd/yy)	Tobacco user[1] ❑ Yes ❑ No

RELATIONSHIP TO APPLICANT	SOCIAL SECURITY NUMBER[2]	PRIMARY CARE PROVIDER (PCP)	MEDICARE STATUS ❑ Covered ❑ Eligible ❑ None	SEX ❑ Male ❑ Female

OPTIONAL *(Fill in all that apply)*

RACE/ETHNICITY: ❑ White ❑ Black or African American ❑ Asian ❑ American Indian or Alaska Native ❑ Native Hawaiian or Other Pacific Islander ❑ Other Race ❑ Two or More Races

HISPANIC/LATINO: ❑ Yes ❑ No

PREFERRED LANGUAGE: ❑ English ❑ Spanish ❑ Hmong ❑ Albanian ❑ Vietnamese ❑ Chinese ❑ Russian ❑ Laotian ❑ Pennsylvania Dutch ❑ Karen ❑ German ❑ Arabic ❑ Polish ❑ French ❑ Korean ❑ Tagalog ❑ Other: _____

DEPENDENT TWO

First Name	Middle initial	Last name	Birth date (mm/dd/yy)	Tobacco user[1] ❑ Yes ❑ No

RELATIONSHIP TO APPLICANT	SOCIAL SECURITY NUMBER[2]	PRIMARY CARE PROVIDER (PCP)	MEDICARE STATUS ❑ Covered ❑ Eligible ❑ None	SEX ❑ Male ❑ Female

OPTIONAL *(Fill in all that apply)*

RACE/ETHNICITY: ❑ White ❑ Black or African American ❑ Asian ❑ American Indian or Alaska Native ❑ Native Hawaiian or Other Pacific Islander ❑ Other Race ❑ Two or More Races

HISPANIC/LATINO: ❑ Yes ❑ No

PREFERRED LANGUAGE: ❑ English ❑ Spanish ❑ Hmong ❑ Albanian ❑ Vietnamese ❑ Chinese ❑ Russian ❑ Laotian ❑ Pennsylvania Dutch ❑ Karen ❑ German ❑ Arabic ❑ Polish ❑ French ❑ Korean ❑ Tagalog ❑ Other: _____

DEPENDENT THREE

First Name	Middle initial	Last name	Birth date (mm/dd/yy)	Tobacco user[1] ❑ Yes ❑ No

RELATIONSHIP TO APPLICANT	SOCIAL SECURITY NUMBER[2]	PRIMARY CARE PROVIDER (PCP)	MEDICARE STATUS ❑ Covered ❑ Eligible ❑ None	SEX ❑ Male ❑ Female

OPTIONAL *(Fill in all that apply)*

RACE/ETHNICITY: ❑ White ❑ Black or African American ❑ Asian ❑ American Indian or Alaska Native ❑ Native Hawaiian or Other Pacific Islander ❑ Other Race ❑ Two or More Races

HISPANIC/LATINO: ❑ Yes ❑ No

PREFERRED LANGUAGE: ❑ English ❑ Spanish ❑ Hmong ❑ Albanian ❑ Vietnamese ❑ Chinese ❑ Russian ❑ Laotian ❑ Pennsylvania Dutch ❑ Karen ❑ German ❑ Arabic ❑ Polish ❑ French ❑ Korean ❑ Tagalog ❑ Other: _____

DEPENDENT FOUR

First Name	Middle initial	Last name	Birth date (mm/dd/yy)	Tobacco user[1] ❑ Yes ❑ No

RELATIONSHIP TO APPLICANT	SOCIAL SECURITY NUMBER[2]	PRIMARY CARE PROVIDER (PCP)	MEDICARE STATUS ❑ Covered ❑ Eligible ❑ None	SEX ❑ Male ❑ Female

OPTIONAL *(Fill in all that apply)*

RACE/ETHNICITY: ❑ White ❑ Black or African American ❑ Asian ❑ American Indian or Alaska Native ❑ Native Hawaiian or Other Pacific Islander ❑ Other Race ❑ Two or More Races

HISPANIC/LATINO: ❑ Yes ❑ No

PREFERRED LANGUAGE: ❑ English ❑ Spanish ❑ Hmong ❑ Albanian ❑ Vietnamese ❑ Chinese ❑ Russian ❑ Laotian ❑ Pennsylvania Dutch ❑ Karen ❑ German ❑ Arabic ❑ Polish ❑ French ❑ Korean ❑ Tagalog ❑ Other: _____

DEPENDENT FIVE				
First Name Middle initial Last name		Birth date (mm/dd/yy)	Tobacco user[1] ❑ Yes ❑ No	
RELATIONSHIP TO APPLICANT	**SOCIAL SECURITY NUMBER[2]**	**PRIMARY CARE PROVIDER (PCP)**	**MEDICARE STATUS** ❑ Covered ❑ Eligible ❑ None	**SEX** ❑ Male ❑ Female

OPTIONAL *(Fill in all that apply)*

RACE/ETHNICITY: ❑ White ❑ Black or African American ❑ Asian ❑ American Indian or Alaska Native ❑ Native Hawaiian or Other Pacific Islander ❑ Other Race ❑ Two or More Races

HISPANIC/LATINO: ❑ Yes ❑ No

PREFERRED LANGUAGE: ❑ English ❑ Spanish ❑ Hmong ❑ Albanian ❑ Vietnamese ❑ Chinese ❑ Russian ❑ Laotian ❑ Pennsylvania Dutch ❑ Karen ❑ German ❑ Arabic ❑ Polish ❑ French ❑ Korean ❑ Tagalog ❑ Other: _____

If an individual's last name is different from the applicant's, explain the reason:

Do all of the dependent(s) listed reside at the same address as the primary applicant? ❑ Yes ❑ No

If No, list dependent(s) name and address: _____

OTHER TYPES OF COVERAGE[3]

For each listed in sections I and II who, at any time in the three month period before the date of this application, **had or continues to have health coverage of any type**, provide the following information.

FIRST AND LAST NAME	NAME OF INSURER	TYPE OF COVERAGE[3]	COVERAGE START DATE	COVERAGE END DATE (IF APPLICABLE)

TOBACCO USER[1]

Tobacco user is defined as using tobacco products (for example cigarettes, cigars, smokeless tobacco, e-cigarettes) four or more times a week on average (other than for religious or ceremonial purposes) within the last six months. This only applies to individuals age 21 and over.

SOCIAL SECURITY NUMBER[2]

Federal law requires that we ask for Social Security Numbers for mandatory reporting to the IRS each year. This field is requested but not required. Please note that the numbers are not used in determining eligibility for coverage.

TYPE OF HEALTH COVERAGE[3]

Choose from the following: Employer-sponsored group coverage (Group), COBRA or state continuation coverage (COBRA), individual medical coverage, Medicare, Medicaid, BadgerCare Plus, state CHIP or other health coverage (explain):

III. LIMITED OPEN ENROLLMENT EVENT ELECTION INFORMATION

Below is a chart of limited open enrollment events that allow you to apply for coverage under a Aspirus Health Plan individual plan outside of the annual open enrollment period. If you are applying under a limited open enrollment event, please check the appropriate box and provide a copy of the required written proof/documentation with your completed application and applicable premium.

Please provide the date of event (month, day, year): _____ / _____ / _____

Limited Open Enrollment Event	Election Period & Examples of Required Proof/Documentation	Coverage Effective Date
Involuntary Loss of Minimum Essential Coverage (MEC): ❑ 1. Loss of eligibility for employer-sponsored group coverage that is not COBRA/continuation (e.g., due to termination of employment). ❑ 2. Employer discontinued benefit plan. ❑ 3. Employer discontinued premium contributions for coverage that is not COBRA/continuation. ❑ 4. COBRA/continuation coverage is exhausted. ❑ 5. Divorce or legal separation from subscriber. ❑ 6. Death of subscriber. ❑ 7. Loss of dependent status (e.g. Due to turning age 26). ❑ 8. Loss of eligibility for Medicaid, state CHIP or loss of pregnancy-related coverage under Medicaid or state CHIP or a loss of access to health care services through coverage provided to the pregnant woman's unborn child through Medicaid or state CHIP. ❑ 9. Loss of individual or employer sponsored group coverage due to a move outside your HMO service area. (For loss of group coverage, no other benefit package is available to you).	Coverage must be elected during the period that begins 60 days before or 60 days after the date coverage ends. 1. COBRA notice or letter from employer and Certificate of Creditable Coverage. 2. Letter from employer. 3. Letter from prior insurer or letter from COBRA administrator. 4. Court documents and Certificate of Creditable Coverage. 5. Letter from employer and death certificate. 6. Letter from prior insurer and Certificate of Creditable Coverage. 7. Written notice from government program. 8. Letter from employer and Certificate of Creditable Coverage. Examples of documentation Aspirus Health Planmay require for proof of recent residency change: • Current utility bill from both old and new address. • Change of address document from the U.S. Post Office. • Current and prior driver's license. **In addition to the above required proof, an individual must provide proof of enrollment in MEC, proof that you lived in a foreign country or U.S. territory for at least 1 day during the 60 day period prior to the loss of MEC or proof that you lived in a service area where no qualified health plan was available through MNsure for at least 1 day during the 60 day period prior to the loss of MEC during the most recent open enrollment or special enrollment period.**	If you timely elect coverage on or before the date of the loss of MEC, your coverage effective date will be the first day of the month following the loss of MEC. If you elect coverage after the date of the loss of MEC, your coverage effective date will be the first day of the month following receipt of your completed application and applicable premium.
You experience a loss of coverage as follows: ❑ Non-renewal or expiration of a non-calendar Year group or individual plan coverage, qualified small employer health reimbursement arrangement or non-calendar year employer-sponsored group coverage.	Coverage must be elected during the period that begins 60 days before or 60 days after the date coverage ends. 1. COBRA notice or letter from employer and Certificate of Creditable Coverage. 2. Letter from employer. 3. Letter from prior insurer or letter from COBRA administrator. 4. Court documents and Certificate of Creditable Coverage. 5. Letter from employer and death certificate. 6. Letter from prior insurer and Certificate of Creditable Coverage. 7. Written notice from government program. 8. Letter from employer and Certificate of Creditable Coverage. Examples of documentation Aspirus Health Plan may require for proof of recent residency change: • Current utility bill from both old and new address. • Change of address document from the U.S. Post Office. • Current and prior driver's license. **In addition to the above required proof, an individual must provide proof of enrollment in MEC, proof that you lived in a foreign country or U.S. territory for at least 1 day during the 60 day period prior to the loss of MEC or proof that you lived in a service area where no qualified health plan was available through MNsure for at least 1 day during the 60 day period prior to the loss of MEC during the most recent open enrollment or special enrollment period.**	If you timely elect coverage on or before the date of the loss of coverage, your coverage effective date will be the first day of the month following the loss of coverage. If you elect coverage after the date of the loss of coverage, your coverage effective date will be the first day of the month following receipt of your completed application and applicable premium.
You newly gain or become a spouse or newly gain an eligible dependent through: ❑ Birth of a newborn. ❑ Adoption/placement for adoption. ❑ Marriage. ❑ Issuance of court ordered health coverage (e.g., medical child support order or other court order).	Coverage must be elected during the period that begins 60 days before and ends 60 days after the date coverage ends. Examples of documentation Aspirus Health Plan may require for this event: • Letter from employer and Certificate of Creditable Coverage. • Letter from employer and letter from prior insurer. • Renewal notice from employer or prior insurer.	Birth/Adoption/Placement or Court Order: Effective the date of the event or the effective date set forth in the court order; or the 1st day of the month following plan selection and receipt of the completed application and applicable premium. Marriage: The first day of the month after receipt of the completed application and applicable premium.

Gaining access to a new qualified health plan: ❑ You permanently move to a Wisconsin service area or to a new service area in Wisconsin, which caused you to gain access to a new qualified health plan.	**Coverage must be elected within 60 days after the date of the event.** Examples of documentation Aspirus Health Plan may require for proof of recent residency change: • Current utility bill from both old and new address. • Change of address document from the U.S. Post Office. • Current and prior driver's license. **In addition to the above required proof, an individual must provide proof of enrollment in MEC, proof that you lived in a foreign country or U.S. territory for at least 1 day during the 60 day period prior to the loss of MEC or proof that you lived in a service area where no qualified health plan was available through MNsure for at least 1 day during the 60 day period prior to the loss of MEC during the most recent open enrollment or special enrollment period.**	If you timely elect coverage on or after the date of a permanent move your coverage effective date will be the first day of the month following receipt of your completed application and applicable premium, but not earlier than the date you gained access to a new qualified health plan as a result of your permanent move.
You newly gain access to a/an: ❑ Individual coverage health reimbursement arrangement (HRA) ❑ Qualified small employer health reimbursement arrangement (QSEHRA)	**Coverage must be elected during the period that begins 60 days before or 60 days after the date coverage ends.** Examples of documentation Aspirus Health Plan may require: • Proof of offer of an individual health plan (HRA) • Proof that your employer has provided you a qualified small employer health reimbursement arrangement (QSEHRA).	Special rules apply based on when you apply and when your coverage under an individual coverage HRA or a QSEHRA take effect.
❑ Other (Explain):	Depends on the type of event.	Depends on the type of event.

Note: If you fail to elect coverage timely, you must wait until the next annual open enrollment period to elect coverage, unless you experience another limited open enrollment event. Written proof of your qualifying event must be submitted with your completed application form and applicable premium.

IV. COVERAGE SELECTION

1. You must be a resident in one of the following counties in Wisconsin in order to apply for coverage; Adams, Clark, Columbia, Florence, Forest, Iron, Juneau, Langlade, Lincoln, Marathon, Marquette, Oneida, Portage, Price, Sauk, Shawano, Taylor, Vilas, Waushara and Wood.

By completing this enrollment form I attest that I am a resident of a Wisconsin county listed above at the time of completing this form.

2. Select a Plan Option.

3. Current Member with a Special Enrollment Event (check one):

a. ❑ I want to keep my current plan option but am adding a dependent.

b. ❑ I want to enroll in a different plan option - select your option below.

4. Make Your Election. Deductible and out-of-pocket maximums listed below are for individuals in-network. Family deductibles are two time the individual. Please see Summary of Benefits and Coverge for non-participating provider benefits and more detailed policy benefits.

	Plans	Deductible	Coinsurance	Out-of-Pocket	Tele Medicine Copay	Convenient Care Clinic copay	Office Visit Copay	Prescription Drugs Preventive, Tier 1, Tier 2, Tier 3, Specialty
HMO PLANS								
❑	**Bronze 8550**	$8,550	0%	$8,550	D/C	D/C	D/C	$0 preventive, D/C all others
❑	**Bronze 6500** with 3 Free PCP Visits	$6,500	20%	$8,550	D/C	D/C	First 3 PCP visits free then D/C	$0 preventive, D/C all others
❑	**Bronze 7200**	$7,200	40%	$8,150	D/C	D/C	D/C	$0 / $20 / $40 / $70 / $750 Ded. 40% Coins.
❑	**Silver 7150**	$7,150	0%	$7,150	$0	$10	$35 PCP $70 Specialist	$0 / $20 / $40 / $70 / $750 Ded. 40% Coins.
❑	**Silver 4500**	$4,500	30%	$8,150	$0	$10	$35 PCP $70 Specialist	$0 / $20 / $40 / $70 / $750 Ded. 40% Coins.
❑	**Silver 5000** with 3 Free PCP Visits	$5,000	20%	$8,150	$0	$10	$35 PCP $70 Specialist	$0 / $20 / $40 / $70 / $750 Ded. 40% Coins.
❑	**Gold 2500**	$2,500	20%	$5,000	$0	$10	$35 PCP $70 Specialist	$0 / $15 / $30 /$45 / 30% Coins.
❑	**Catastrophic* 8550** with 3 Free PCP Visits	$8,550	0%	$8,550	D/C	D/C	First 3 PCP visits free then D/C	$0 preventive, D/C all others

	Plans	Deductible	Coinsurance	Out-of-Pocket	Tele Medicine Copay	Convenient Care Clinic copay	Office Visit Copay	Prescription Drugs Preventive, Tier 1, Tier 2, Tier 3, Specialty
HMO PLANS - HSA QUALIFIED PLANS								
❑	**HDHP Bronze 6900**	$6,900	0%	$6,900	D/C	D/C	D/C	$0 preventive, D/C all others
❑	**HDHP Bronze 6000**	$6,000	30%	$6,950	D/C	D/C	D/C	$0 preventive, D/C all others
❑	**HDHP Silver 2800**	$2,800	20%	$6,900	D/C	D/C	D/C	$0 preventive, D/C all others
❑	**HDHP Silver 4500**	$4,500	0%	$4,500	D/C	D/C	D/C	$0 preventive, D/C all others
❑	**HDHP Silver 5500**	$5,500	0%	$5,500	D/C	D/C	D/C	$0 preventive, D/C all others
POS - Copay Plans								
❑	**Silver 7150**	$7,150	0%	$7,150	$0	$10	$35 PCP $70 Specialist	$0 / $20 / $40 / $70 / $750 Ded. 40% Coins.
❑	**Silver 5000** with 3 Free PCP Visits	$5,000	20%	$8,150	$0	$10	$35 PCP $70 Specialist	$0 / $20 / $40 / $70 / $750 Ded. 40% Coins.
POS - HSA QUALIFIED PLANS								
❑	**HDHP Bronze 6000**	$6,000	30%	$6,950	D/C	D/C	D/C	$0 preventive, D/C all others
❑	**HDHP Silver 2800**	$2,800	20%	$6,900	D/C	D/C	D/C	$0 preventive, D/C all others

D/C = Deductible and Coinsurance PCP = Primary Care Practitioner

* Eligibility limited to Persons under age 30 or those with a hardship exemption from the Federally Facilited Marketplace.

These policies do not include pediatric dental services. Pediatric dental coverage is an essential health benefit that can be purchased as a stand-alone plan through the marketplace at HealthCare.gov. Please contact your broker or HealthCare.gov (1-800-318-2596).

V. INITIAL PAYMENT OPTION **AND** ONGOING PAYMENT ELECTION

Step 1. Initial Payment *(check one)*

❑ **I have enclosed a check with my application form**

❑ **Authorization via Credit Card - Credit Card Type (check one):** ❑ Visa ❑ MasterCard ❑ American Express

Name of Credit Card Holder (first and last) _____

Street Address _____

City _____ State _____ Zip _____

Credit Card Number: _____ CVV # (on back of card):_____ Expiration Month/Year: _____

❑ **Electronic Payment Plan (EPP)* Authorization Form**

Name on Bank Account _____

Bank ABA/Routing Number _____

Bank Account Number _____

Bank Name _____

Print Name of Applicant _____

Signature of Bank Account Holder _____ Date _____

Signature of Bank Account Holder (if joint account) _____

Step 2. Ongoing Payment *(check one)*

❑ **Monthly Bill to My Home Address** **or** ❑ **Monthly Bill to the following Address**

Name _____ Street _____

City _____ State _____ Zip _____

❑ **Authorization via Credit Card - Credit Card Type (check one):** ❑ Visa ❑ MasterCard ❑ American Express

Name of Credit Card Holder (first and last) _____

Street Address _____

City _____ State _____ Zip _____

Credit Card Number: _____ CVV # (on back of card):_____ Expiration Month/Year: _____

❑ **Monthly Electronic Payment Plan (EPP)***

Name on Bank Account _____

Bank ABA/Routing Number _____

Bank Account Number _____

Bank Name _____

Print Name of Applicant _____

Signature of Bank Account Holder _____ Date _____

Signature of Bank Account Holder (if joint account) _____

***Electronic Payment Plan (EPP)**

Electronic Payment Plan premium collection option, which utilizes the Automated Clearing House (ACH) system to effectively and accurately debit your designated account each payment cycle. The ACH funds transfer system is used nation-wide by member financial institutions. On or around the 1st of each month we will initiate a transfer from your account for the monthly premium payment due. This process will continue on a monthly basis during the contract period. In the event your account lacks sufficient funds, you may be charged a processing fee of up to $25 fee for each occurrence. If you have questions, please contact Aspirus Health Plan at 1-866-631-4611.

VI. CERTIFICATION/UNDERSTANDING NOTICE

CERTIFICATION: I represent and certify all of the following: • no answer or information in this application was provided by the agent or anyone else (except for information provided by other family members); • such representations are true, accurate, and complete to the best of my knowledge.

UNDERSTANDING: I understand: the representations I make, together with any supplemental representations that I make, shall be the basis for the Insurer to issue any coverage; • that no agent has the authority to waive an answer to any question, pass on insurability, make or alter any contract, or waive or alter any of the Insurer's other rights or requirements; • that no coverage will be effective unless and until the date specified by the Insurer after this application has been approved by the Insurer; • any misrepresentation contained herein may be used to reduce or deny a claim, or to rescind and void coverage and the policy within the contestable period, if such misrepresentation materially affects the Insurer's acceptance of the risk, including approving any person for coverage. I understand that the Insurer has no liability for anything the agent said or failed to say before, during, or after the application process, that's not subsequently confirmed in writing by an authorized officer of the Insurer, including, but not limited to, answers given by the agent in response to questions asked by myself, my spouse, or my dependent(s). Furthermore, I understand that the Insurer is not liable for any statement, representation, or other information provided to myself, my spouse, or my dependent(s) that isn't expressly contained in a written document provided to them and signed by an authorized officer of the Insurer.

I understand that the Insurer fully complies with the regulations and orders regarding doing business with foreign countries or foreign nationals listed on the Office of Foreign Assets Control's Specially Designated Nationals and Blocked Persons (SDN) list. Therefore, the Insurer may rescind and void any coverage if it determines that you, your spouse, or any named dependent are either listed on the SDN list or associated with an entity listed on the SDN list. I understand and acknowledge that any person who, with intent to defraud or knowledge that he/she is facilitating a fraud against an Insurer, submits an application or files a claim containing a false and deceptive statement is committing a fraudulent act, which is a crime. I further understand and acknowledge that in some states, any person who, for the purpose of misleading an Insurer or other person, conceals significant information from an application or claim is committing a fraudulent act.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

IF YOU ARE REPLACING OTHER INDIVIDUAL OR GROUP HEALTH COVERAGE, PLEASE READ THIS SECTION.

According to your application or the information furnished by you, you intend to lapse or otherwise terminate your present policy and replace it with a policy to be issued by the Insurer. For your own information and protection, certain facts shown below should be pointed out to you. If the Insurer approves your application for coverage and issues a policy, you should consider these facts before you lapse or terminate your present policy.

- Your new policy provides a time limit within which you may decide, without cost to you, whether you desire to keep the policy. The time limit is 10 days from the date of receipt of this policy.
- Health conditions which you presently may have might not be covered under the new policy. This change in coverage could result in a claim for benefits being denied under the new policy even though they are payable under your present policy.
- Questions in the application for the new policy must be answered truthfully and completely; if not, the validity of the policy and the payment of any benefits thereunder may be rescinded and voided.

VII. AGENT STATEMENT

Did an agent or sales representative assist you in the completion of this application? ❑ Yes ❑ No

If yes, agent must complete the following:

I asked the applicant, spouse and all child(ren) over age 18 all questions contained in this application and recorded their answers exactly as given to me. I also represent that no other person provided any of their answers, or influenced any of their answers; if any of their answers were influenced by another person, I have attached a written explanation thereof to this application.

Writing Agent's Name (Print) | Agent's Phone Number

Agent's Name | Writing Agent's NPN Number

Writing Agent's Signature | Date Signed by Agent

VIII. 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 Third Party Administrator ("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. 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 agree that no insurance will be effective until the date specified by the company on the policy after this application has been accepted.

Name of Person Providing Assistance (if applicable)

IV. ACKNOWLEDGEMENTS AND SIGNATURES

I acknowledge that:

- This application becomes part of my Contract.
- The signatures shown below allow me, my spouse, or my agent (Section VII) to release to Insurer information about any person listed on my Individual and Family plan application documents.
- Under the Health Insurance Portability and Accountability Act (HIPAA), Insurer, without my authorization, may only release limited information about my selection of a plan to my spouse, adult/minor children, producer, or anyone else.
- Insurer 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 Insurer Contract.
- I have read and agree to the Terms and Conditions (Section VII) included with this application.
- I authorize Insurer to disclose information about the selection of a plan to the Agent of Record (Section VII) for the duration of coverage and final reconciliation of the Insurer account. A signed Customer Authorization to Disclose Health Plan Information form is required for all other disclosures to the Agent of Record.

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 Contract 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.

❑ Signature: This application has been signed by me and my spouse, 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 Signature (if applicable): | Date

Mail to: Aspirus Health Plan, Inc., Attn: Individual Plans, P.O. Box 1062, Minneapolis, MN 55440 **Fax:** 715.257.6163 **Call:** 1.866.631.4611 **AspirusHealthPlan.com/Individual**

Internal Use Only - Notes