Individual Insurance Open Enrollment and Special Enrollment Application

When to Apply

- Applications will be accepted during an annual open enrollment period (November 1, 2025 - January 15, 2026).
- 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 time frame 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 IV. 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

- Mail the completed application including additional documentation or written proof required to:
  Aspirus Health Plan
  Attn: Individual Product Department
  PO Box 1890
  Southampton, PA 18966
  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

- Applying during Open Enrollment (November 1, 2025 - January 15, 2026): Your application must be received by December 15, 2025 in order to begin coverage on January 1, 2026. Applications received December 16th through January 15th will be given a February 1, 2026 effective date.
- Applying outside Open Enrollment (Special Enrollment): The coverage effective date depends on the type of special enrollment event. Refer to section IV.
- 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.

Contact Us

- Please contact the Aspirus Health Plan Individual Product Sales Department at 1.866.631.4611 if you have questions or need assistance completing your application.

ASPIRUS HEALTH PLAN

Individual Insurance Open Enrollment and Special Enrollment Application
PO Box 1890
Southampton, PA 18966
1.866.631.4611

AGENT INFORMATION

Agent Name

OFFICE USE ONLY
Application ID#: _____

I. Applicant Information

Instructions: Please complete all applicable areas of this application. Please print using black ink.

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: _____

[1,2] refer to page 4 for definition

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	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: _____

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	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: _____

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	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: _____

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	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: _____

DEPENDENT FIVE

[1,2] refer to page 4 for definition

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	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: _____

If you have additional dependents, please include an extra page with your application stating their information.

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. Effective Date

Open Enrollment (November 1, 2025 - January 15, 2026)
Your application and initial premium must be received by the 15th of December in order to begin coverage on January 1, 2026 as set forth herein. Applications and initial premium received December 16th through January 15th will be given a February 1, 2026 effective date as set forth herein.

Special Enrollment
Your effective date of coverage depends on the type of special enrollment event. See section IV for details on available effective dates.

I am requesting my coverage start on (month, day, year): _____ / _____ / _____

IV. 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 (November 1, 2025 -January 15, 2026). 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): _____ / _____ / _____

Please provide the date of loss of coverage (month, day, year): _____ / _____ / _____ *(This is different from when the event occurred.)*

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. 10. An individual or his or her dependent is enrolled in COBRA or state continuation coverage for which an employer is paying all or part of the premiums, or for which a government entity is providing subsidies, and the employer completely ceases its contributions to the individual's or dependent's COBRA continuation coverage or government subsidies completely cease.	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 Healthcare.gov 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.
Upon expiration of a non-calendar year group healthplan, individual health plan, or, qualified small employer health reimbursement arrangement.	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 Healthcare.gov 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.**	The date of the loss of coverage is the last day of the plan year. 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 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.

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

Plan ID	Plan Name	Deductible	Coinsurance	Out-of-Pocket	Convenient Care Clinic copay	Office Visit Copay ****	Prescription Drugs Preventive, Tier 1, Tier 2, Tier 3, Specialty
HMO - COPAY PLANS							
86584WI0010011	**Bronze 7500 *****	$7,500	50%	$10,000	$50	$50 PCP $100 Specialist	$0 / $25 / Ded then $50 / Ded then $100 / Ded then $500
86584WI0010001	**Silver 6600**	$6,600	30%	$8,600	$10	$40 PCP $80 Specialist	$0 / $20 / $40 / Ded then $80 / Ded then $350
86584WI0010012	**Silver 6000 ***	$6,000	40%	$8,900	$40	$40 PCP $80 Specialist	$0 / $20 / $40 / Ded then $80 / Ded then $350
86584WI0010007	**Gold 2700**	$2,700	30%	$7,000	$10	$30 PCP $60 Specialist	$0 / $15 / $30 / $60 / $250
86584WI0010015	**Gold 2000 ***	$2,000	25%	$8,200	$30	$30 PCP $60 Specialist	$0 / $15 / $30 / $60 / $250
86584WI0010016	**HMO Bronze $0 Medical Deductible********	*0%*	*50%*	*$9,450*	*$10*	*$35 PCP $200 Specialist*	*$0/$35/$125, D/C all others*
86584WI0010008	**Catastrophic 10600***** with 3 Free PCP Visits**	$10,600	0%	$10,600**	D/C	D/C	$0 preventive, D/C all others
HMO - DEDUCTIBLE PLANS							
86584WI0010009	**Bronze 10000*****	$10,000	0%	$10,000	D/C	D/C	$0 preventive, D/C all others
86584WI0010013	**HDHP Silver 5900*****	$5,900	0%	$5,900	D/C	D/C	$0 preventive, D/C all others

	Plan ID	Plan Name	Deductible	Coinsurance	Out-of-Pocket	Convenient Care Clinic copay	Office Visit Copay ***	Prescription Drugs Preventive, Tier 1, Tier 2, Tier 3, Specialty
POS - COPAY PLANS								
	86584WI0020005	**Bronze 7500 *****	$7,500	50%	$10,000	$50	$50 PCP $100 Specialist	$0 / $25 / Ded then $50 / Ded then $100 / Ded then $500
	86584WI0020001	**Silver 6000 ***	$6,000	40%	$8,900	$40	$40 PCP $80 Specialist	$0 / $20 / $40 / Ded then $80 / Ded then $350
POS - HSA QUALIFIED PLANS								
	86584WI0020003	**Bronze 8500*****	$8,500	30%	$9,500	D/C	D/C	$0 preventive, D/C all others

D/C = Deductible and Coinsurance Ded = Deductible PCP = Primary Care Practitioner HMO = Health Maintenance Plan POS = Point-of-Service Plan

* Standardized plan option
** Eligibility limited to persons under age 30, or those with a hardship exemption from the Federally Facilitated Marketplace.
*** Separate RX Deductible $1500
**** The same benefit applies to telemedicine.
***** HSA Qualified Plan

VI. 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 ☐ Discover
Check box if you would like payment to be recurring.

Name as it appears on card

Street Address	City	State	Zip Code

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

ELECTRONIC PAYMENT PLAN (EPP)* AUTHORIZATION FORM *(Check one):*
Account type: Checking Savings
Check box if you would like payment to be recurring.

Name on Bank Account	Bank Routing Number	Bank Account Number	Bank Name

Name of Applicant

Signature of Bank Account Holder	Date

Signature of Bank Account Holder *(if joint account)*	Date

ONGOING PAYMENT *(Check one):*
Monthly bill sent to my home address
Monthly bill sent to the following address

Name

Street Address	City	State	Zip Code

***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 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. If you have questions, please contact Aspirus Health Plan at 1.866.631.4611.

VII. 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 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 NPN Number

Agent's Signature | Date

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)* | Date

IX. Acknowledgments 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 VIII) 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 1890, Southampton, PA 18966 **Fax:** 715.257.6163 **Call:** 1.866.631.4611 **aspirushealthplan.com**

Internal Use Only - Notes

Nondiscrimination & Language Access Policy

Discrimination is Against the Law. 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, or sex, (including sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation, gender identity and sex stereotypes), consistent with the scope of sex discrimination described at 45 CFR § 92.10l(a)(2). Aspirus Health Plan, Inc. does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Aspirus Health Plan, Inc.:
Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:

- Qualified sign language interpreters.
- Written information in other formats (large print, audio, accessible electronic formats, other formats).

Provides free language assistance services to people whose primary language is not English, which may include:

- Qualified interpreters.
- Information written in other languages.

If *you* need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact the Nondiscrimination Grievance Coordinator at the address, phone number, fax number, or email address below.

If you believe that Aspirus Health Plan, Inc. has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex ,*you* can file a *grievance* with:

Nondiscrimination Grievance Coordinator
Aspirus Health Plan, Inc.
PO Box 1890
Southampton, PA 18966-9998
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/portaljlobby.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. This notice is available at Aspirus Health Plan, lnc.'s website: https://aspi rushealth plan.com/webd ocs/70021-AH P-NonDiscrim_Lang-Assist-N otice.pdf.

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 الهاتف1-866-631-5404(رقم هاتف الصم والبك : 711)

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 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 numer1-866-631-5404 (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 al1-866-631-5404 (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).