ASSURE SELF-INSURED APPLICATION and CHANGE FORM

network health

Name of Employer: House of Hope Green Bay	Date of Full-Time Employment:
Group #/Class: 2002445	Effective Date/Date of Change:

Coverage	Reason for Application/Change		
☒ EPO	☐ New Subscriber	☐ Address Change	
☐ HMO	☐ Add Dependent	☐ Benefit Plan Change	Dependent addition reason:
☐ POS	☐ Termination	☐ COBRA/Continuation	Termination reason:
☐ Network Options	☐ Dependent Termination	☐ Open Enrollment	Dependent termination reason:
☐ Other	☐ Name Change	☐ Waiver of Insurance	Other:

Employee Information

Last Name:	Legal First Name:	Nickname:	MI:	**Status (check)**
Address/Apt. #:				☐ Single ☐ Married
City:	State:	Zip:	Email:	
Home Phone:		Work Phone:		

Enrollment Section (attach additional sheets of paper if necessary)

	Name (Last, First, MI)	Birth Date MM/DD/YY	Sex	Disabled	Relationship	Primary Care Practitioner Name (Strongly recommended)	Current Patient?
Self	SSN # _____		☐ M ☐ F	☐ Yes ☐ No	Self		☐ Yes ☐ No
Sp.	SSN # _____		☐ M ☐ F	☐ Yes ☐ No	Spouse		☐ Yes ☐ No
Dep 1	SSN # _____		☐ M ☐ F	☐ Yes ☐ No	☐ Child ☐ Stepchild		☐ Yes ☐ No
Dep 2	SSN # _____		☐ M ☐ F	☐ Yes ☐ No	☐ Child ☐ Stepchild		☐ Yes ☐ No
Dep 3	SSN # _____		☐ M ☐ F	☐ Yes ☐ No	☐ Child ☐ Stepchild		☐ Yes ☐ No

Network Health Plan (NHP) and/or Network Health Insurance Corporation (NHIC), as applicable, requires all legal paperwork for insuring dependents involving guardianship and adoption.

Other Insurance Coverage Information

Do you or any dependents have other group medical insurance including Medicare?	☐ Yes	☐ No
If Yes, does this other policy include pharmacy coverage?	☐ Yes	☐ No
Will this insurance continue after Network Health Plan begins?	☐ Yes	☐ No
Individuals who have other coverage:	Policyholder:	
Name of insurance company:	Policy #:	
Is there a divorce decree establishing insurance responsibility?	☐ Yes	☐ No
Name of responsible party:	Birth Date:	

Please provide Network Health Plan with a copy of the portion of the decree which states this responsibility.

Over for signature →

Confidentiality Statement

I understand that the answers provided here within will be relied upon by the Plan Sponsor for administrative purposes and, if applicable, in the issuance of a Summary Plan Description. **I declare all statements contained in this entire form about me and my dependents are true and correct to the best of my knowledge and that no material information has been withheld or omitted. I understand that my intentional misrepresentation of a material fact in this form may be used as the basis to rescind, terminate or modify coverage for me or my dependents. Rescind means that the coverage was never in effect.**

I agree that no coverage will be effective until the date specified by the Plan Sponsor in the Summary Plan Description. I authorize my employer to deduct the necessary contribution toward the benefits. I reserve the right to revoke this deduction authorization at any time upon my written notice which may result then in loss of coverage under the plan. Benefits are effective only after approval by the Plan Sponsor or Administrator and satisfaction of any probationary period. Any person who knowingly and with intent to defraud, submits an application/change form or files a claim containing any materially false information may be found guilty of fraud, which is a crime, in a court of law and may be subject to fines and confinement in prison.

I agree that a photographic copy of this authorization shall be as valid as the original and that this authorization shall be valid for 2 ½ years from the date shown below. I understand that I may request a copy of this authorization. I understand that I may revoke this authorization at any time in writing unless action has been taken in reliance on my authorization. Should I refuse to sign this authorization, I understand it may affect my enrollment or change request (and my dependents' enrollment or change request) in the benefit plan. All pages must be attached and complete, including this authorization for this form to be considered complete.

If this form is incomplete, it may be rejected. If an additional authorization for the release of my (or my dependents') medical records is necessary, I (or my dependents) will be required to sign an authorization for the release of this information prior to enrollment in the plan. The information on this application is valid for a maximum of 90 days from the date of the signature.

Employee signature is not required in a cancellation due to termination, but must be signed by the employer.

Employee Signature	Date	Employer Signature	Date

Network Health Plan and/or Network Health Insurance Corporation Internal Use Only:

Effective Date	Entered By	Date

Plans administered by Network Health Administrative Services, LLC. And Stop Loss Insurance Underwritten by Network Health Insurance Corporation.

Email this completed / signed form to: nhcommercialenrollment@networkhealth.com

Or fax: 920-720-1904

Or mail to: Network Health
1570 Midway Pl.
Menasha, WI 54952