Enrollment Application

Small Employer Transitional and Grandfathered
Large Employer Grandfathered and Non-Grandfathered

Important Notices Regarding Your Enrollment Application

To properly administer your health benefit plan, a certain amount of information is required.

Please note the following:

- If you or any of your eligible dependents do not enroll for medical coverage with Avera Health Plans when it is first made available and want to enroll later, you must wait until the next open enrollment period unless you have a qualifying life event and are eligible for a special enrollment period.
- If the subscriber is required by court or administrative order to provide health care coverage to a dependent, a copy of the court or administrative order must be submitted to the plan.
- Any incomplete or missing information will delay the processing of the enrollment request.
- The completed application must be received by Avera Health Plans to be considered valid.
- If you commit fraud or intentionally misrepresent your answers on this application, Avera Health Plans has the right to rescind your policy.
- Avera Health Plans reserves the right to change premium rates upon renewal.
- Your signature on the attached enrollment form verifies that you have read and understand the enclosed statements and acknowledge that all information provided on the enrollment form is complete and true.

Avera Health Plans

5300 S. Broadband Ln.
Sioux Falls, SD 57108-2221
Phone: 605-322-4545
Fax: 605-322-4689
Toll Free: 1-888-322-2115
enrollment@averahealthplans.com

Enrollment Application

Must be completed by the employer:

Employer Name: _____
Group Number: _____
Employer Location: _____
Requested Effective Date: _____
☐ New Hire: _____
☐ Special Enrollment: Reason: _____
☐ Open Enrollment: _____
☐ Add Newly Acquired Dependent(s)
☐ COBRA: Reason: _____
Date COBRA began: _____

SUBSCRIBER INFORMATION

_____ — _____ — _____ _____ _____ _____
Social Security Number (not printed on ID cards) | Subscriber Name (Last) | (First) | (M.I.)

_____ _____ _____ _____ _____
Mailing Address | City | State | ZIP | County

_____ _____ _____ _____
Home Phone | Work Phone | Email Address | Primary Care Physician

_____ ☐ Male ☐ Female ____FT ____IN _____Pounds ☐ Single ☐ Married ☐ Separated ☐ Divorced
Date of Birth | Height | Weight

☐ Hourly or ☐ Salary _____ Average hours worked per week: ____
Date of Hire

PLAN SELECTION

Availability based on your employer's selection. (Check Box)

☐ Single ☐ Family ☐ Employee/Child(ren) ☐ Employee/Spouse ☐ Employee + One Benefit Plan Selection (for multiple options) _____

FAMILY INFORMATION

Complete for covered dependents only. (If more space is needed, attach an additional sheet of paper, sign and date it.)

Legal Last Name, First Name, Middle Initial		Gender (M/F)	Relationship*	Birth Date (Mo/Dy/Year)	Social Security Number	Height	Weight	City and State if address is different than Employee's
02	Spouse		Spouse			__FT ___IN	___LBS	
03	Child					__FT ___IN	___LBS	
04	Child					__FT ___IN	___LBS	
05	Child					__FT ___IN	___LBS	
06	Child					__FT ___IN	___LBS	

*Eligible dependents are defined only as married spouse and natural dependent children, stepchildren, adopted children or children under legal custody who are within the limiting age.
NOTE: If your adult children are between the ages of 19 and 26 and have access to Employer Sponsored Health Coverage, please notify your employer.

INSURANCE WAIVER SECTION

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan provided that you request enrollment within 30 days after your other coverage ends. 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 your dependent(s), provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

I have been informed that an employer-sponsored health benefit plan is available through my employer to my dependents and me. On behalf of myself and my dependents, I am voluntarily electing not to enroll in the health benefit plan sponsored by my employer.

I am not applying for coverage because:

☐ I am covered by another employer group benefit plan (please list) _____
☐ My dependents are covered by another employer group benefit plan (please list) _____
☐ I am covered by an individual benefit plan (please list) _____
☐ Other reason (please explain) _____

AUTHORIZATION TO RELEASE INFORMATION TO AVERA HEALTH PLANS

By signing this application, I authorize any consumer reporting agency, medical information bureau, insurance company, or other person having information about me or my dependents to release to Avera Health Plans or any of its designees any and all records or information pertaining to medical history, health history questions, health statement or health services rendered to me or my dependents, including drug and/or alcohol abuse information, or any information regarding responsibility for payment to Avera Health Plans for any administrative purpose.

I also authorize Avera Health Plans, its employees and agents, to disclose records and information as permitted by law to authorized persons including other insurers or reinsurers, vendors of employee insurance or cafeteria plans. Avera Health Plans may be compensated by other insurers or vendors. A copy of this authorization is as valid as the original. Unless otherwise stated or revoked by my written revocation, this authorization terminates when enrollment in Avera Health Plans terminates. This information will be used to determine eligibility for benefits, payment responsibility, and medical necessity review. I agree to abide by the documents describing my coverage, (including but not limited to the Certificate of Coverage, Member Handbook and Summary of Benefits and Coverage, the Evidence of Coverage and Summary Plan Document) and to pay any applicable premiums, co-payments, coinsurance and deductibles. I understand that my enrollment or eligibility for benefits in Avera Health Plans is conditional upon me signing this authorization and that failure to sign may result in being denied enrollment or benefits.

Subscriber's Signature: _____ Date: _____

Employer's Representative Signature (Required): _____ Date: _____

OTHER INSURANCE INFORMATION

If you have other health insurance, we will coordinate your benefits with your other health insurance. Have you, your spouse or any of your dependent children been covered by any other group, medical, hospital or surgical insurance, including Medicare, Medicaid or Medicare Disability? ☐ YES ☐ NO

If you checked YES, please attach a Certificate of Creditable Coverage for yourself and each dependent covered by the prior carrier.

Insurance Carrier: _____ Phone: _____ Policy Number: _____

Effective Date: _____ Termination Date: _____

Will this coverage end before the Avera Health Plans effective date? ☐ YES ☐ NO

Type of Coverage with Prior Carrier: ☐ Single ☐ Family ☐ Employee/Child(ren) ☐ Employee/Spouse

HEALTH HISTORY QUESTIONS

To better serve you, please complete the following. In the last five years, has any person on the application for health insurance ever had or ever been treated or diagnosed by a physician or a medical professional for (health history questions optional for Small Employer Transitional and Small Employer Grandfathered):

☐ YES ☐ NO Lung conditions (For example: chronic lung disease, cystic fibrosis, allergies or asthma)
☐ YES ☐ NO Bone, joint, muscle conditions (For example: arthritis, fractures, joint replacement, osteoporosis or chronic back pain)
☐ YES ☐ NO Cancer
☐ YES ☐ NO Stomach and/or bowel conditions (For example: Crohn's disease, pancreatitis, heartburn, ulcers, colitis)
☐ YES ☐ NO Congenital disease or disorders
☐ YES ☐ NO Endocrine conditions (For example: thyroid, diabetes)
☐ YES ☐ NO Drug or alcohol abuse
☐ YES ☐ NO Heart disorders or illness (For example: high blood pressure, heart attack, chest pain, stroke, heart disease or congestive heart failure)
☐ YES ☐ NO Blood disorders (For example: HIV/AIDS, hepatitis or hemophilia)
☐ YES ☐ NO Mental health issues
☐ YES ☐ NO Are you currently pregnant? If Yes, how many weeks gestation are you? ___ weeks
Are you high risk? ☐ YES ☐ NO
Are you having multiple babies? ☐ YES ☐ NO
Have you had or are you having pre-term labor? ☐ YES ☐ NO
☐ YES ☐ NO Is there an auto accident or Workers' Compensation case pending?
☐ YES ☐ NO Are there any other conditions, disorders, illnesses or diseases for which further diagnostic tests, consultations, observation, treatment or surgery or hospitalization has been recommended?

HEALTH STATEMENT (If you checked **YES** to any of the health questions on this form, please complete this section.)

Name of Person	Name of Condition	Dates and Duration of Treatment	Type of Treatment	Indicate Degree of Recovery Partial – Half – ¾ – Full
				☐25% ☐50% ☐75% ☐100%
				☐25% ☐50% ☐75% ☐100%
				☐25% ☐50% ☐75% ☐100%
				☐25% ☐50% ☐75% ☐100%
				☐25% ☐50% ☐75% ☐100%

Please list all current medications: _____

_____

Information provided will be reviewed by Avera Health Plans Population Health Services.

☐ I am sending additional medical information to:
Avera Health Plans Population Health Services, 5300 S. Broadband Ln., Sioux Falls, SD 57108-2221.

If you commit fraud or intentionally misrepresent your answers on this application, Avera Health Plans has the right to rescind your policy.

➢ Your initials below verify that you have read and understand the enclosed statements and acknowledge that all the information on this form is complete and true.

Initial: _____ Date: _____

INTERNAL USE ONLY	
Underwriting Initials	Score

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Discrimination is Against the Law

Avera Health Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Avera Health Plans does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Avera Health Plans:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these services, contact the Avera Health Plans Service Center at 1-888-322-2115, (TTY 711), 8 a.m. to 5 p.m. CST, Monday through Friday.

If you believe that Avera Health Plans 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:

Complaint and Appeals Coordinator
Avera Health Plans
5300 S. Broadband Ln.,
Sioux Falls, SD 57108-2221

Fax 1-800-269-8561
Email ComplaintAppeals@AveraHealthPlans.com

You can file a grievance in person or by mail, fax, or email. You may also contact the Complaint and Appeals Coordinator if you need assistance with filing a complaint.

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 call 1-800-368-1019 or 1-800-537-7697 (TDD). Or mail:

US Department of Health and Human Services,
200 Independence Avenue SW Room 509F, HHH Building,
Washington, D.C. 20201

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

Avera Health Plans

Getting Help in Other Languages

Language assistance services are available free of charge. Our Service Center is available 8 a.m. to 5 p.m. CST, Monday – Friday, toll-free at 1-888-322-2115 (TTY: 1-800-877-1113).

- ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-322-2115 (TTY: 1-800-877-1113).
- LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-888-322-2115 (TTY: 1-800-877-1113).
- CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-322-2115 (TTY: 1-800-877-1113).
- XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-888-322-2115 (TTY: 1-800-877-1113).
- 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1-888-322-2115 (TTY: 1-800-877-1113) 。
- ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-322-2115 (TTY: 1-800-877-1113).
- ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-322-2115 (телетайп: 1-800-877-1113).
- ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-322-2115 (رقم هاتف الصم والبكم: 1-800-877-1113).
- ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-322-2115 (TTY: 1-800-877-1113).
- ဟ်သူဉ်ဟ်သး– နမ့်ကတိၤ ကညီ ကျိာ်အဃိ. နမၤနဲ့ ကျိာ်အတ်မၤစၢၤလၢ တလာ်ဘူဉ်လာ်စ့ၤ နီတမံၤဘဉ်သ့နူဉ်လီၤ. ကိး 1-888-322-2115 (TTY: 1-800-877-1113).
- ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-322-2115 (ATS: 1-800-877-1113).
- 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-322-2115 (TTY: 1-800-877-1113) 번으로 전화해 주십시오.
- ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-888-322-2115 (መስማት ለተሳናቸው: 1-800-877-1113).
- OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-322-2115 (TTY - Telefon za osobe sa oštećenim govorom ili sluhom: 1-800-877-1113).
- ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-888-322-2115 (TTY: 1-800-877-1113)។