ENROLLMENT APPLICATION

3816 S Elmwood Avenue, Suite 100
Sioux Falls, SD 57105
Phone: (605) 322-4545
Fax: (605) 322-4689
Toll-free: 1 (888) 322-2115
www.AveraHealthPlans.com

Please forward to Avera Health Plans **at this address** upon completion to allow timely processing of request.

MUST BE COMPLETED BY 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 # (not used on ID cards) Subscriber Name (Last) (First) (M.I.)

____

Street or Mailing Address City State ZIP Code County

____

Home Phone Work Phone E-mail Address Primary Care Physician Hourly or Salary

__/__/______ ☐ Male ☐ Female ________ ________ ☐ Single ☐ Married ☐ Separated ☐ Divorced __/__/____ ____________

Date of birth Height Weight Date of hire Average hrs worked per week

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

☐ Single ☐ Family ☐ Employee/Child(ren) ☐ Employee/Spouse ☐ Employee + One Benefit Plan Selection (for dual 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/Day/Yr)	Social Security No.	Height	Weight	Full-Time Student** (Yes/No)	If Yes, Name of College or University Attending
02	Spouse								
03	Child								
04	Child								
05	Child								
06	Child								

*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.
Student Verification must be submitted with this application for any dependent who has reached the limiting age of 19.

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

Print Name: ____________________ Signature: ____________________ Date: ____________

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 utilization review. I agree to abide by the documents describing my coverage, (including but not limited to the Certificate of Coverage, Member Handbook and Benefit Summary, 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: ____________________

OTHER INSURANCE INFORMATION

IN THE PAST 62 DAYS:
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

List Insurance Carrier: ____________________ List Phone #: ____________________ List Policy #: ____________________

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

Effective date: ____________________ Termination Date: ____________________

Will this coverage cease prior to the Avera Health Plans effective date? ☐ YES ☐ NO

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

HEALTH HISTORY QUESTIONS

If your answers, or lack thereof, to any questions in this Enrollment Application are incorrect or untrue, Avera Health Plans has the right to deny benefits or rescind your policy. It is a criminal offense to supply false or fraudulent information on this Enrollment Application.

In the last five (5) 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:

☐ YES ☐ NO Lung conditions (For example: chronic lung disease, cystic fibrosis, allergies, asthma, etc.)
☐ YES ☐ NO Bone, joint, muscle conditions (For example: arthritis, fractures, joint replacement, osteoporosis, chronic back pain, etc.)
☐ YES ☐ NO Cancer
☐ YES ☐ NO Stomach and/or bowel conditions (For example: Crohn's disease, pancreatitis, heartburn, ulcers, colitis, etc.)
☐ YES ☐ NO Congenital disease or disorders
☐ YES ☐ NO Endocrine conditions (For example: thyroid, diabetes, etc.)
☐ YES ☐ NO Drug or alcohol abuse
☐ YES ☐ NO Heart disorders or illness (For example: high blood pressure, heart attack, chest pain, stroke, heart disease, congestive heart failure, etc.)
☐ YES ☐ NO Blood disorders (For example: HIV/AIDS, hepatitis, hemophilia, etc.)
☐ YES ☐ NO Mental health issues
☐ YES ☐ NO Are you currently pregnant? If Yes, how many weeks gestation are you?________
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	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 Medications** you are currently taking: ______________________________

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Information provided will be reviewed by Avera Health Plans Medical Management.

☐ I am sending additional medical information to ATTN: Medical Management, Avera Health Plans, 3816 S Elmwood Avenue, Suite 100, Sioux Falls, SD 57105.

If your answers, or lack thereof, to any questions in this Enrollment Application are incorrect or untrue, Avera Health Plans has the right to deny benefits or rescind your policy. The best time to clarify any questions is now, before a claim is filed. If for any reason your answers on the Enrollment Application are not correct, contact Avera Health Plans immediately and report the correct information. It is a criminal offense to supply false or fraudulent information on this Enrollment Application.

- 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