CITY OF WISCONSIN RAPIDS
HEALTH INSURANCE ENROLLMENT APPLICATION

Instructions: Please complete all applicable areas of this application. Please print using black ink. Aspirus Health Plan, Inc. ("Aspirus Health Plan" or "Insurer") or Third-Party Administrator ("TPA") does NOT guarantee approval of this application for any person, or issuance of a policy.

When complete, please return this form to City of Wisconsin Rapids' Human Resources Department.

Section 1—Employer Information *(to be filled out by employer)*

Employer Name: **City of Wisconsin Rapids**		
Group Number: **ASP10005**	Subgroup:	Class:

Section 2—Employee Information

First Name		Middle Initial		Last Name			
Mailing Address				Apartment or Suite Number		Social Security Number	
City			State			ZIP code	
Daytime Phone Number		Email Address				Date of Birth	

Gender ☐ Male ☐ Female	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Employee Start Date	Hours Worked Per Week

Race or ethnicity:

☐ Caucasian/White ☐ African American/Black ☐ Alaskan
☐ American Indian or Native ☐ Asian ☐ Hispanic or Latino
☐ Native Hawaiian or Pacific Islander ☐ Southeast Asian
☐ Two or more races

☐ Other _____

What primary language is spoken in your home?

☐ English ☐ Albanian ☐ Arabic ☐ Chinese ☐ French ☐ German
☐ Hmong ☐ Korean ☐ Laotian ☐ Pennsylvania Dutch ☐ Polish
☐ Russian ☐ Spanish ☐ Tagalog ☐ Vietnamese

☐ Other _____

Aspirus Health Plan is committed to supporting an eco-friendly environment. The communications you receive from us will be available on your member portal.

Section 3—Reason for Application

☐ New Employee ☐ New Group Enrollee

☐ New Enrollee due to Annual Open Enrollment **(application must be received prior to the policyholder's anniversary date)**

☐ Special Enrollment due to: **Please provide the date of the qualifying event:** _____

- ☐ Involuntary loss of Minimum Essential Coverage for any reason other than fraud, intentional misrepresentation of a material fact or failure to pay premium
- ☐ Marriage
- ☐ Birth
- ☐ Adoption or placement for adoption or appointment of legal guardianship
- ☐ Other: _____

☐ COBRA—Reason: _____ Start Date: _____ Termination Date: _____

☐ Add Dependent(s)

☐ Changing: _____ to _____ Effective Date: _____

☐ Change Benefit Plan—Current: _____ Change to: _____

☐ Change Network Option—Current: _____ Change to: _____

☐ Change PCP—Please indicate which covered member is changing PCPs and the new PCP information in Section 6.

☐ Deleting Coverage (Explain): _____

☐ Other—Please indicate: _____

Section 4—Type of Health Coverage Requested

Type of Coverage	Applying For	Waiving/Declining Coverage For
Group Medical Coverage:	☐ Myself ☐ My Spouse ☐ My Dependents	☐ Myself ☐ My Spouse ☐ My Dependents

Section 5—Applicant Enrollment Information

Please complete the following for all family members who are applying for coverage. If additional space is needed, please attach a separate sheet with completed information.

Dependent Name				Sex	Social Security Number	Relationship to Applicant	Date of Birth
First		MI		☐ Male ☐ Female			
Last							
First		MI		☐ Male ☐ Female			
Last							
First		MI		☐ Male ☐ Female			
Last							
First		MI		☐ Male ☐ Female			
Last							
First		MI		☐ Male ☐ Female			
Last							

Section 6—Information Regarding Primary Care Practitioners

NOT REQUIRED - Please select a Primary Care Practitioner (PCP) for yourself, your spouse, and each dependent who is applying for coverage. If additional space is needed, please attach a separate sheet with completed information.

Last Name	First Name	MI	Primary Care Practitioner	Clinic	Location

Section 7—Information Regarding Other Health Coverage and Medicare

Does any person applying for coverage currently have other individual or group health coverage? ☐ Yes ☐ No
If yes, please provide coverage information below. If additional space is needed, please attach a separate sheet with completed information.

Policyholder Information	Name, Address, and Phone Number of Insurance Company/Plan Type	Policy Number	Type of Coverage	Effective Date of Coverage
Name: _____ ☐ Employee ☐ Spouse Date of Birth: _____			☐ Single ☐ Family	
			☐ COBRA	COBRA Effective Date: COBRA Termination Date:
Name: _____ ☐ Employee ☐ Spouse Date of Birth: _____			☐ Single ☐ Family	
			☐ COBRA	COBRA Effective Date: COBRA Termination Date:

Are you or any of your family members eligible for Medicare? ☐ Yes ☐ No
If yes, please complete the following or attach a copy of your Medicare card.
Name of person covered by Medicare: _____ Medicare Card Number: _____
Is Medicare eligibility due to: ☐ Over age 65 ☐ End-Stage Renal Disease (ESRD) ☐ Total Disability
Effective Dates: Part A: _____ Part B: _____ Part C (Medicare Advantage): _____ Part D: _____

Section 8—Health Coverage Waiver

If anyone named on this application is waiving or declining any coverage, please provide his/her name and check the reason he/she is waiving/declining:
Name(s) of person(s) waiving/declining:

_____

☐ I am covered or will be covered under another plan that is not sponsored by my employer.
☐ My dependents are covered or will be covered under another plan that is not sponsored by my employer.
☐ Other:_____

Waiver: I certify that I have been given the opportunity to apply for group coverage and decline to enroll as indicated on behalf of me and/or my dependents. I understand that by signing this waiver, I and/or my dependents forfeit the right to coverage.

I understand that if I am declining enrollment for myself or my dependents (including my spouse) because of other health coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that I request enrollment within 31 days after my coverage ends. In addition, if I have a new dependent as a result of marriage, birth, adoption or placement for adoption, I understand that I may be able to enroll myself and my dependents provided that I request enrollment within 31 days after the marriage, birth or adoption. I further understand that, other than these qualifying events, if this form is submitted after the enrollment period, I cannot enroll until the next annual enrollment period, if applicable.

_____ _____ _____

SIGNATURE OF EMPLOYEE (required if waiving coverage) **PRINT NAME** **DATE**

Section 9—Notice of Special Enrollment Rights for Health Coverage

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose coverage (or if the employer stopped contributing toward you or your dependent's other coverage).

Loss of coverage events include, but are not limited to: (a) the person no longer lives, resides or works within his or her HMO service area, the HMO does not provide coverage for that reason, and there is no other coverage under the plan for the individual; (b) a dependent loses dependent status because he or she attains a particular age; (c) the plan no longer offers any benefits to a class of similarly situated individuals (such as if the plan terminates coverage for all part-time workers); and (d) a benefit package option terminates or the issuer stops operating in the group market.

However, you must request enrollment within 31 days (or 60 days for Medicaid eligibility, birth or adoption of a child) after you or your dependent's other coverage ends (or after the employer stops contributing toward the other coverage).

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 yourself and other dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

This notice is for informational purposes only and is informing you of your special enrollment rights.

Section 10—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 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.

If any payroll deductions are required for this coverage, I authorize such deductions from my earnings. I reserve the right to revoke this deduction authorization at any time upon written notice to the employer.

An Application should not be submitted more than 45 days prior to the effective date. This document will become a part of the insurance contract when coverage is approved and issued.

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. I agree that no insurance will be effective until the date specified by the company on the policy after this application has been accepted. I also understand that if I decline any coverage, future changes in coverage are NOT automatic and may be subject to Insurer or TPA's approval.

Name of Person Providing Assistance (if applicable): _____

Section 11—Acknowledgement and Signatures

I acknowledge that:

- This application becomes part of my Medical Coverage Agreement.
- The signatures shown below allow me, my spouse/domestic partner to release to Insurer or TPA information about any person listed on my Individual and Family plan application documents.
- Under the Health Insurance Portability and Accountability Act (HIPAA), Insurer or TPA, without my authorization, may only release limited information about my selection of a plan to my spouse/domestic partner, adult/minor children, producer, or anyone else.
- Insurer or TPA 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 Medical Coverage Agreement.
- I have read and agree to the Terms and Conditions (Section 10) included with this application.

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 Medical Coverage Agreement may be cancelled 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.

For more information on Special Enrollment Period requirements, please visit our website: AspirusHealthPlan.com.

☐ **Signature**: This application has been signed by me and my spouse/domestic partner, 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/domestic partner/dependent signature (if applicable): _____ Date:_____

For contact information, please see below.

Mail:
Aspirus Health Plan, Inc.
Attn: Enrollment
P.O. Box 1062
Minneapolis, MN 55440

Call:
866-631-5404

Visit:
AspirusHealthPlan.com