Employee Name (please print): _____

P.O. Box 91110
Sioux Falls, SD 57109
(605) 328-6800 • (800) 752-5863
Fax: (605) 328-6812
sanfordhealthplan.com

SANFORD HEALTH PLAN

Application for Simplicity/Sanford TRUE Small Group Health Insurance 2019

To be completed by Human Resource Representative

Group Name _____ Group/Division Name _____

Effective Date _____ Date of Hire _____

Reason for Enrollment: ❑ New Hire ❑ Open Enrollment ❑ Special Enrollment Reason _____
(Please Specify)

Company Representative's Signature _____ Date: _____

Send originals to: PO Box 91110, Sioux Falls, SD 57109-1110

This section must be completed. Incomplete forms will be returned which may cause processing delays.

Help understanding this document is free.

If you would like this policy in another format (for example, a larger font size or a file for use with assistive technology, like a screen reader), please call us at (800) 752-5863 (*toll-free*) | TTY/TDD: (877) 652-1844 (*toll-free*).

Help in a language other than English is also free.

Please call (800) 892-0675 (*toll-free*) to connect with us using free translation services.

1. Employee Information

First Name, M.I., Last Name	SS #	Date of Birth (MM/DD/YY)	Age	Gender
		____/____/_____		☐ M ☐ F

Complete Mailing Address	City	State	Zip Code	County

Home Phone	Work Phone	Email Address

Marital Status	Primary Language Spoken	Tobacco User[4]
☐ Married ☐ Single ☐ Divorced/Separated	☐ English ☐ Spanish ☐ Other: _____	☐ Y ☐ N

Family Physician	Clinic Name	City	State	Phone Number

2. Coverage Election

Sanford *Simplicity*: ☐ $500 ☐ $1,250 ☐ $1,750 ☐ $2,250 ☐ $2,700 HDHP ☐ $3,500 ☐ $4,500 HDHP ☐ $5,000 ☐ $6,000

Sanford TRUE: ☐ $500 ☐ $1,250 ☐ $1,750 ☐$2,250 ☐ $2,700 HDHP ☐ $3,500 ☐ $4,500 HDHP ☐ $5,000 ☐ $6,000

☐ NONE – I am declining coverage because I and/or my dependents have coverage through:
- ☐ Spouse's Group Health Plan
- ☐ Other, Explain: _____

3. Dependent Information

First Name/M.I./Last Name	Relationship (Spouse/ Dependent)[1]	Gender (M/F)	Date of Birth (MM/DD/YY)	SS #	If over 26, full time student (Y/N)	Medicare eligible[2] or disabled[3] (Y/N)	Tobacco used during past 4 months?[4] (Y/N)

Do all of the dependent(s) listed above reside at the same address as the employee?

Employee Name (please print): _____

☐ Yes ☐ No If No, list dependent(s) name and address: _____

Provide additional information if answered 'Yes' above:

1. Health plans can request your Social Security Number, but cannot deny coverage based on lack of Social Security Number. For this application, we need your Social Security Number for Form 1095-B, which is provided to you in addition to being reported to the Internal Revenue Service.
2. For North Dakota and Minnesota applicants: If the unmarried parent of the grandchild is a covered eligible dependent and both the parent and grandchild are primarily dependent on the subscriber. Grandchildren must reside with subscriber.
3. For South Dakota applicants: If the dependent is over age 26 and under age 30, and a full-time college student, please provide name of school/university, city and state:_____
4. For Iowa applicants: If dependent is a full-time college student, please provide name of school/university, city and state: _____
5. Name and Medicare number if applicable: _____
6. Is disabled person(s) eligible for Medicare? ☐ Yes ☐ No If Yes, please list names and Medicare number: _____
7. Tobacco products include cigarettes, cigars, pipes, chewing tobacco, nicotine products or any other form of tobacco. Sanford Health Plan cannot charge tobacco rates to individuals who are under eighteen.

8. Other Insurance Information

a) Are you or any of your family members currently or have previously been enrolled with Sanford Health Plan?
☐ Yes ☐ No If Yes, who? List ID# _____

b) Will you or any of your family members be covered by another health policy after the effective date of enrollment with Sanford Health Plan?
☐ Yes ☐ No If yes, you must complete the following information to coordinate benefits.

Person Insured	Employer of Insured	Insurance Company	Policy Number	Effective Date

9. HIPAA Authorization for Pre-Enrollment Uses and Disclosures of Member Information

I hereby authorize the use or disclosure of personal health information about me as described below.

I authorize Sanford Health Plan to use the personal health information I have provided on the application form to determine my eligibility to obtain coverage under the health benefits plan, for which I have applied, and to determine the rates and terms which apply to the plan/policy. I also authorize all health care providers and pharmacy benefit managers who have provided treatment or other health care services to me to disclose all information regarding my treatment to Sanford Health Plan. The following group of persons employed or working for Sanford Health Plan may use my personal health information disclosed herein: employees of the Underwriting, Flex and Customer Service departments. The information which is disclosed by health care providers may be used by Sanford Health Plan to determine my eligibility to obtain coverage under the health benefits plan, for which I have applied, and to determine the rates and terms which apply to the plan/policy. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by Sanford Health Plan in reliance on this authorization, by sending a written revocation to Sanford Health Plan, Attn: Customer Services, PO Box 91110, Sioux Falls, SD 57109-1110. I understand that the information which will be provided under this authorization is necessary for Sanford Health Plan to determine my eligibility for coverage under the health benefits plan and that Sanford Health Plan will condition enrollment in the health benefits plan/policy on my providing this authorization, and my application may be denied if I refuse to provide this authorization. I understand that if the person or entity that receives my personal health information is a not a health care provider or health plan covered by the federal privacy regulations, the information may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations. In the case of this authorization, however, the information described above will be received by a health plan which is covered by the federal privacy regulations, and will not be used or redisclosed except as described above, and the information will continue to be protected under the federal privacy regulations.

_____ _____ _____

Applicant Name or Legal Representative[1] (print) Applicant Signature Date

[1]If you are the legal representative of the applicant and are not the parent of a minor, you must attach evidence of your authority to act as the applicant's representative for this authorization to be valid (i.e. Power of Attorney).

10. Signature

On behalf of myself and my eligible dependents listed above, I hereby agree to the conditions of enrollment attached hereto. If applicable, my employer is authorized to deduct from my earnings the necessary premium contributions, if any, required of me.

X Signature of Employee _____ Date: _____

11. Special Enrollment Notice

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 dependent's lose eligibility for that other coverage (or if the employer stops contributing toward you or your dependents other coverage). However, you must request enrollment within 31 days after you or your dependents' other coverage ends (or after the employer stops contributing

Employee Name (please print): _____
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 your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact our Customer Services Department at (605) 328-6800 or toll free at (800) 752-5863.

12. Genetic Information Nondiscrimination Act of 2008 (GINA)

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

13. Notice of Non-Discrimination

Sanford Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis

Sanford Health Plan complies with applicable federal civil rights laws, and does not discriminate on the basis of race, color, national origin, age, disability, gender, gender identity, sex, or sexual orientation.

Sanford Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, gender, gender identity, sex, sexual orientation, medical condition, including current or past history of a mental health and substance use disorder; religion; religious beliefs; housing status; or sources of payment for care.

Sanford Health Plan:

- Provides free aids and services to people with disabilities 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 services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact our Civil Rights Coordinator.

If you believe that Sanford Health Plan 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 Sanford Health Plan Customer Services by calling (800) 752-5863 (toll-free) | TTY/TDD: (877) 652-1844 (toll-free) or by writing Sanford Health Plan, PO Box 91110, Sioux Falls SD 57109-1110.

You can file a grievance in person or by mail or phone. If you need these services, our Civil Rights Coordinator is here to help.

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 *ocrportal.hhs.gov/ocr/portal/lobby.jsf,* or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-868-1019, 800-537-7697 (TDD).

Complaint forms are available at *hhs.gov/ocr/office/file/index.html*

14. Michelle's Law

Federal law requires that we provide the following notice regarding Michelle's Law [Public Law 110-381]. Please note that changes in federal law may eliminate certain elements of Michelle's Law, and the Plan intends to provide continuing coverage of Eligible Dependents up to age twenty-six (26), irrespective of their student status, for Plan Years beginning on or after September 23, 2010.

A Dependent Child enrolled in, and attending, an accredited college, university, trade, or secondary school at least five (5) months each year will remain covered if the Dependent takes a medically necessary leave of absence from school or changes to part-time status. The leave of absence must:

1. Be medically necessary;
2. Commence while the child is suffering from a serious illness or injury; and
3. Cause the child to lose coverage under the plan.

Students are only eligible as long as they were covered by their parent's health insurance policy prior to diagnosis. Coverage will continue until the earlier of one year from the first day of the leave of absence or the date on which coverage would otherwise terminate because the child no longer meets the requirements to be an Eligible Dependent (e.g., reaching the plan's limiting age).

Employee Name (please print): _____

You must provide a signed, written documentation from the Dependent Child's treating Practitioner/Provider stating all of the following: 1) the Dependent Child is suffering from a serious illness or injury necessitating a medical leave of absence; 2) the treating Practitioner/Provider certifies such leave of absence is Medically Necessary; and 3) the dates when the Dependent will be either on a medically necessary leave of absence from school or will be changing to part-time status due to a serious illness or injury.

15. Conditions of Enrollment

I agree for myself and on behalf of my eligible dependents to the following conditions of enrollment in Sanford Health Plan (hereafter referred to as the Plan).

1. We will abide by the rules and regulations of the Plan.
2. We will be bound by the eligibility requirements as stated in the Member Handbook, benefits, deductibles, copayments, coinsurance, exclusions, limitations, and other terms of the health maintenance contract and certificate of coverage.
3. We will complete and submit to the Plan such concepts, releases and other assignments as are reasonably necessary for the Plan in accordance with its rights under the health maintenance contract and certificate of coverage, to coordinate with other group health benefit plans or group insurance policies. I shall cooperate with and assist the Plan with respect to such coordination of benefits.
4. We will pay any copayments, deductibles or coinsurance as is required by the health maintenance contract or certificate of coverage directly to those providers who provide the health care services.
5. We acknowledge that we will be personally liable to the Plan for the usual and customary cost of any Health Care Services received during a time we are not eligible for coverage under the Certificate of Coverage.

Health Plan Use Only

Mark category after audit is complete. Circle if information is incorrect and return to enrollment processor for corrections.

☐ Social Security #
☐ Group #
☐ Effective date
☐ Date of hire
☐ Name spelling
☐ Sex (male/female)
☐ Dependent student on review
☐ Address
☐ Date of birth
☐ Other insurance information
☐ Other: _____

Auditor: _____ Date: _____

Processor: _____ Date: _____