Application for Group Health Insurance

P.O. Box 91110
Sioux Falls, SD 57109
(605) 328-6800
(800) 752-5863
Fax: (605) 328-6811
sanfordhealthplan.com

SANFORD HEALTH PLAN

This section must be completed by Human Resource Representative.
Incomplete forms will be returned and may cause processing delays.

Group Name:_____ Group/Division Number: _____

Effective Date:_____ Date of Hire: _____

Reason for Enrollment: □New Hire □Open Enrollment □Late Entrant □Special Enrollment Reason: _____

Signature of Company Representative_____ Date: _____

Please send originals to: PO Box 91110, SD 57109-1110

Employee Information

First Name, M.I., Last Name	Social Security #	Date of Birth (MM/DD/YY)

Mailing Address (Street Address)	City	State	Zip Code	County

E-mail Address

Primary Phone Number	Work Phone Number	Family Physician

Gender: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced/Separated ☐ Other

What is your primary language? ☐ English ☐ Spanish ☐ Other _____

Coverage Election

☐ YES- I am electing coverage
Deductible Choice: _____

Network Choice: □Broad □Tiered □Focused

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

Dependent Information – List all family members to be covered. Use additional sheet, if needed.

First Name, M.I., Last Name	Gender (M/F)	Date of Birth (MM/DD/YY)	Social Security #	Relationship[1]	Full Time Student[2] (Y/N)	Family Physician

Do all of the dependent(s) listed above reside at the same address as the employee? ☐ Yes ☐ No
If no, list dependent(s) name and address: _____

Provide additional information if answered 'Yes' above:

[1] 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.

[2] 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:

_____

_____

[2] For Iowa applicants: If dependent is a full-time college student, please provide name of school/university, city and state:

_____

Other Insurance Information

Are you currently, or have you been previously enrolled with Sanford Health Plan?
☐ Yes ☐ No If Yes, who? List ID# _____

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

List covered family members:

Is anyone named in the application eligible for Medicare? ☐ Yes ☐ No Name/Medicare Number: _____

Health Assessment

Has anyone in this application for health insurance ever had, or ever been treated or diagnosed by a physician or medical professional for any conditions listed below? Provide details in the section provided below.

Yes	No		Yes	No	
☐	☐	AIDS or a positive HIV test	☐	☐	High Cholesterol
☐	☐	Allergy / Asthma	☐	☐	Infertility/Reproductive Organ Disorder
☐	☐	Back or Neck Disorder	☐	☐	Kidney/Bladder/Urinary Disorder
☐	☐	Blood Disorder	☐	☐	Liver Disorder
☐	☐	Bone/Joint/Muscular Disorder	☐	☐	Mental or Nervous Disorder
☐	☐	Cancer	☐	☐	Migraine Headaches
☐	☐	Diabetes/Pancreatic Disorder	☐	☐	Nervous System/Brain Disorder
☐	☐	Digestive/Intestinal Disorder	☐	☐	Respiratory/Lung Disorder
☐	☐	Drug or Alcohol Abuse	☐	☐	Skin Disorder
☐	☐	Eating Disorder	☐	☐	Stroke
☐	☐	Ear, Nose & Throat Disorder	☐	☐	Tumor or Cyst
☐	☐	Heart/Circulatory Disorder	☐	☐	Current Pregnancy; due date _____ /_____ /_____
☐	☐	High Blood Pressure			

Are you or any dependent listed on this application a tobacco user? ☐ Yes ☐ No If yes, list who:_____

List any other condition, treated in the last 10 years, not mentioned above:_____

☐ ☐ In the last year, has anyone received medical treatment apart from routine physicals or immunizations?

☐ ☐ Do you or any of your dependents take any medicines or require shots?

☐ ☐ Do you or any of your dependents have treatments, tests, hospitalization or surgery planned in the future?

Are any of these conditions related to a workers' compensation injury, motor vehicle accident or third party liability claim? If yes, explain:_____

If you checked yes to any health questions above, please complete this section. Use an additional page if needed and include your signature and date.

Name of Person	Name of Condition	Date of Onset and Duration of Treatment	Type of Treatment, Medication, and Degree of Recovery	Name and Address of Physician

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.

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 other coverage).

However, you must request enrollment within 30 days after your or your dependents' 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 your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

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

Genetic Information Nondiscrimination Act of 2008 (GINA)

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Tile 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 of an embryo lawfully held by an individual or family member receiving assistive reproductive services.

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 (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).

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.

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 earning the necessary premium contributions, if any, required of me.

Signature of Employee	Date

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, Customer Service, Flex and Medical Management 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 Service, 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 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).

Health Plan Use Only

Enrollment Application Audit Checklist

Please check off each category after audit is complete. Circle if information is incorrect and return to enrollment processor for corrections.

□ Social Security #	□ Sex (Male/Female)	□ Group #
□ Dependent student on review	□ Effective Date	□ Address
□ Date of hire	□ Date of Birth	□ Name spelling
□ Verify Network Choice	□ Other insurance information	□ Pre-Ex Determination

□ Other:_____

Auditor: _____ Date:_____ Processor:_____
Date:_____