



AFFINITY HEALTH SYSTEM
1570 Midway Place, P.O. Box 120
Menasha, WI 54952

SMALL EMPLOYER EVIDENCE OF HEALTH ENROLLMENT FORM

PLEASE TYPE OR PRINT IN INK
SHADED AREA TO BE COMPLETED BY EMPLOYER

SPECIAL ENROLLMENT	
<input type="checkbox"/> BIRTH	<input type="checkbox"/> ADOPTION
<input type="checkbox"/> MARRIAGE	<input type="checkbox"/> LOSS OF COVERAGE

NAME OF EMPLOYER			GROUP NUMBER	LATE ENROLLMENT		DATE HIRED / RE-HIRED (CIRCLE ONE) FULL-TIME	
EMPLOYEE'S LAST NAME			LEGAL FIRST NAME	NICK NAME	M.I.	OCCUPATION	EFFECTIVE DATE OF COVERAGE
STREET ADDRESS / APT. NO.					HOURS WORKED PER WEEK	PRODUCT NAME	
CITY			STATE	ZIP	COUNTY	TOTAL EMPLOYEES	
HOME TELEPHONE		WORK TELEPHONE		MARITAL STATUS			SEX
				<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED			<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE

If anyone named in this application is waiving/declining coverage, please complete the waiver section. If anyone is applying for coverage, please complete the enrollment section.

Applying For:	Waiving/Declining Coverage For:
<input type="checkbox"/> Myself <input type="checkbox"/> My Spouse <input type="checkbox"/> My Dependent Children	<input type="checkbox"/> Myself <input type="checkbox"/> My Spouse <input type="checkbox"/> My Dependent Children

WAIVER SECTION

I hereby certify that I was informed of the availability of coverage under the policy. I have decided not to apply for coverage offered for (check those which apply): Self Spouse Dependent Children

If waiving coverage, please sign below. I understand that if I desire to apply for coverage at a later date I may be considered a Late Enrollee and subject to an 18-month waiting period. Notwithstanding this waiting period, I elect to decline the coverage because:

My dependent(s) and/or I are already covered by a health benefit plan that provides similar or better coverage. **Please attach a copy of both sides of the identification card.**

My dependent(s) and/or I are electing or have elected alternative coverage offered by my employer at this time of enrollment. **Please attach a copy of both sides of the identification card.**

My dependent(s) and/or I do not wish insurance and are without significant health problems.

My dependent(s) and/or I are not insured under a State mandatory risk sharing plan under chapter 619 of the Wisconsin statutes and my premium contribution would be more than 10% of my annual earnings. Please attach a copy of your W-2 form.

Signature _____ (Copy/Fax Valid as Original) Print Name _____ Date Signed _____

ENROLLMENT SECTION (ATTACH ADDITIONAL PAPER IF NECESSARY.)

	NAME (LAST, FIRST, MIDDLE INITIAL)	BIRTH DATE			SEX (M / F)	HEIGHT	WEIGHT	RELATIONSHIP	DISABLED (Y / N)	Required for processing HMO or POS Primary Care Practitioner (First & Last Name)	PCP ID #	ESTABLISHED PATIENT
		MO.	DAY	YR.								
S	SOC. SEC. NO.											<input type="checkbox"/> Yes <input type="checkbox"/> No
S	SOC. SEC. NO.											<input type="checkbox"/> Yes <input type="checkbox"/> No
S	SOC. SEC. NO.							<input type="checkbox"/> CHILD <input type="checkbox"/> STEPCHILD <input type="checkbox"/> GRANDCHILD <input type="checkbox"/> GUARDIANSHIP				<input type="checkbox"/> Yes <input type="checkbox"/> No
S	SOC. SEC. NO.							<input type="checkbox"/> CHILD <input type="checkbox"/> STEPCHILD <input type="checkbox"/> GRANDCHILD <input type="checkbox"/> GUARDIANSHIP				<input type="checkbox"/> Yes <input type="checkbox"/> No
S	SOC. SEC. NO.							<input type="checkbox"/> CHILD <input type="checkbox"/> STEPCHILD <input type="checkbox"/> GRANDCHILD <input type="checkbox"/> GUARDIANSHIP				<input type="checkbox"/> Yes <input type="checkbox"/> No

List any dependents stated above who will NOT be enrolling _____

Do all of the dependents listed above reside at the same address as the employee? YES NO

If no, list dependent name and address _____

Are any of the above dependents age 19 or over full-time students? YES NO If yes, please indicate the name, school attending and status: _____

NAME	SCHOOL	STATUS
		<input type="checkbox"/> Part-Time <input type="checkbox"/> Full-Time
		<input type="checkbox"/> Part-Time <input type="checkbox"/> Full-Time

Have you or your dependents ever been a member of Network Health Plan? YES NO *If previously insured under a different name, please list that name* _____

Do you or any of your dependents have other group medical insurance including Medicare? YES NO

If yes, will this coverage continue concurrently with Network Health Plan? YES NO

If yes, who is the person who holds the other insurance policy and what is the relationship to the insured? _____

Does this other policy include pharmacy coverage? YES NO

List below who is covered under the other group medical insurance, policy number, name of insurance company, and effective date of coverage:

NAME OF COVERED INDIVIDUAL(S)	POLICY NUMBER	NAME OF INSURANCE COMPANY	EFFECTIVE DATE

Is there a divorce decree/court order establishing insurance responsibility? YES NO

If yes, provide Network Health Plan the portion of the decree which states this responsibility. _____

Who is the responsible party? _____

CODED BY	UDRWRTG	APPRD BY	DT APPR	EFFECTIVE DATE	ENTERED BY	DATE
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