



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

- | | |
|---|---|
| <p style="text-align: center;">Applying For:</p> <input type="checkbox"/> Myself <input type="checkbox"/> My Spouse <input type="checkbox"/> My Dependent Children | <p style="text-align: center;">Waiving/Declining Coverage For:</p> <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 P O S	SOC. SEC. NO.											<input type="checkbox"/> Yes <input type="checkbox"/> No
	SOC. SEC. NO.											<input type="checkbox"/> Yes <input type="checkbox"/> No
D E P E N D E N T	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
	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
D E P E N D E N T	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
	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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MEDICAL HISTORY

Do not reveal the results of any HIV or Genetic testing that may have been done in reference to any of the following questions.

1. Has any applicant had any life or health insurance declined, postponed, modified or had a waiver or extra premium added?
 Yes No **If Yes, give reason and dates below.**
2. Has any applicant ever had or been told they have or had any of the following? **Check all which apply and give details below.**
 Heart disorder Chest pain High blood pressure
 Diabetes Cancer Other heart or circulatory disorder
 Epilepsy Tumor Disorder of stomach or intestinal tract
 Angina Stroke Lung or respiratory disorder
 Asthma Ulcer Brain or seizure disorder
 Arthritis Migraine Headaches Reproduction system disorder
 Fainting Back or neck disorder Urinary system disorder
 Dizziness Bone or joint disorder **NONE OF THE ABOVE**
3. Have you or any of your dependents received any mental health counseling or therapy, used drugs other than prescribed by your physician, or been advised to have treatment or been treated for alcohol or drug abuse?
 Yes No **If Yes, give details below and indicate if the treatment is/was inpatient or outpatient.**
4. Is any female applicant currently pregnant? Yes No
If Yes, list the due date and any complications below.
If Yes, previous history of C-Section? Yes No
5. Does any applicant have any physical disability?
 Yes No **If Yes, give details below.**
6. Within the last 3 months, has any applicant listed taken any medication or been under the care of a doctor or other practitioner?
 Yes No **If Yes, give details in the medication section below or list the condition for which you were under care.**
7. Within the last 5 years, has any applicant listed had any surgery or does any applicant have surgery scheduled? Yes No
If Yes, indicate below when the surgery was or will be performed and what surgical procedure was or will be done.
8. Has any applicant ever had or been treated for a sexually transmitted disease? Yes No **If Yes, give details below.**
9. Has any applicant been diagnosed as having AIDS or AIDS related complex by a member of the medical profession?
 Yes No **If Yes, give details below.**
10. Indicate any family member(s) who smoke.
 None Self Spouse _____ (children)
list name(s)

FOR EACH ANSWER YES ABOVE, FILL OUT THE INFORMATION BELOW. (ATTACH ADDITIONAL PAPER IF NECESSARY.)

Indicate Question #	NAME OF APPLICANT	DIAGNOSIS OR NATURE OF ILLNESS/INJURY	DATE DIAGNOSED MO./YR.	DATE(S) OF TREATMENT	FULLY RECOVERED: YES OR NO DEGREE OF RECOVERY	IF HOSPITALIZED LENGTH OF STAY	PROVIDERS NAME AND ADDRESS

MEDICATION INFORMATION (ATTACH ADDITIONAL PAPER IF NECESSARY.)

NAME OF APPLICANT	MEDICATION NAME	DOSAGE	HEALTH CONDITION OR REASON FOR TAKING MEDICATION

SIGNATURE SECTION

SIGNATURE IS REQUIRED FOR ALL EMPLOYEES REQUESTING COVERAGE.

I have read the foregoing statements and declare them to be true and complete to the best of my knowledge and belief. I agree that NHP shall not be liable for any claim on account of illness, injury, or death, the cause of which arose or commenced prior to approval of my request for membership. I realize that any material misstatement in this health history may result in denial of a claim and/or rescission of the group coverage.

I hereby authorize and request any hospital, clinic, institution, physician or other person to furnish NHP or its underwriting agent full particulars of diagnosis, treatment, medical history or any other information and conclusions about me and any member of my family. I understand that this authorization may be used for the purpose of obtaining information in connection with my insurance application and that this authorization shall be valid for 12 months. I accept as valid a photocopy of this authorization and signature.

I request the coverage provided by NHP or its underwriting agent issued to my employer and authorize the required deduction, if any, for this coverage from my wages. I understand and agree that coverage will commence on the date designated by NHP or its underwriting agent.

Signature of Applicant

Date Signed