Avera Health Plans

Enrollment Application for Large Employer Groups

Important Notices Regarding Your Enrollment Application

To properly administer your health benefit plan, a certain amount of information is required.

Please note the following:

- With respect to medical coverage, if you or any of your eligible dependents do not enroll in Avera Health Plans when it is first made available and want to enroll later, you must wait until the next open enrollment period unless a special enrollment exception applies.
- If the subscriber is required by court or administrative order to provide health care coverage to a dependent, a copy of the court or administrative order must be submitted to the plan.
- Any incomplete or missing information will delay the processing of the enrollment request.
- The completed application must be received by Avera Health Plans to be considered valid.
- If you commit fraud or intentionally misrepresent your answers on this application, Avera Health Plans has the right to rescind your policy.
- Avera Health Plans reserves the right to change premium rates upon renewal.
- Your signature on the attached enrollment form verifies that you have read and understand the enclosed statements and acknowledge that all information provided on the enrollment form is complete and true.

Enrollment Application For Large Employer Group

3816 S Elmwood Ave., Suite 100
Sioux Falls, SD 57105-6538
Phone: 605-322-4545
Fax: 605-322-4689
Toll Free: 1-888-322-2115
AveraHealthPlans.com

Must be completed by the employer:

Employer Name: _____
Group Number: _____
Employer Location: _____
Requested Effective Date: _____
☐ New Hire: _____
☐ Special Enrollment: Reason: _____
☐ Open Enrollment: _____
☐ Add Newly Acquired Dependent(s)
☐ COBRA: Reason: _____
Date COBRA began: _____

SUBSCRIBER INFORMATION

___ ___ ___ ___ ___ ___ ___ ___ ___ _____ _____ _____
Social Security # (not printed on ID cards) | Subscriber Name (Last) | (First) | (M.I.)

_____ _____ _____ _____ _____
Street or Mailing Address | City | State | ZIP | County

_____ _____ _____ _____
Home Phone | Work Phone | Email Address | Primary Care Physician

_____ ☐ Male ☐ Female ___FT ___IN _____Pounds ☐ Single ☐ Married ☐ Separated ☐ Divorced
Date of Birth | Height | Weight

☐ Hourly or ☐ Salary _____ Average hours worked per week: _____
Date of Hire

PLAN SELECTION

Availability based on your employer's selection. (Check Box)

☐ Single ☐ Family ☐ Employee/Child(ren) ☐ Employee/Spouse ☐ Employee + One Benefit Plan Selection (for multiple options) _____

FAMILY INFORMATION

Complete for covered dependents only. (If more space is needed, attach an additional sheet of paper, sign and date it.)

	Legal Last Name, First Name, Middle Initial	Gender (M/F)	Relationship*	Birth Date (Mo/Dy/Year)	Social Security Number	Height	Weight	City and State if address is different than Emloyee's
02	Spouse		Spouse			__FT ___IN	___LBS	
03	Child					__FT ___IN	___LBS	
04	Child					__FT ___IN	___LBS	
05	Child					__FT ___IN	___LBS	
06	Child					__FT ___IN	___LBS	

*Eligible dependents are defined only as married spouse and natural dependent children, stepchildren, adopted children or children under legal custody who are within the limiting age.
NOTE: If your adult children are between the ages of 19 and 26 and have access to Employer Sponsored Health Coverage, please notify your employer.

INSURANCE WAIVER SECTION

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan provided that you request enrollment within 30 days after your other coverage ends. 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 your dependent(s), provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

I have been informed that an employer-sponsored health benefit plan is available through my employer to my dependents and me. On behalf of myself and my dependents, I am voluntarily electing not to enroll in the health benefit plan sponsored by my employer.

I am not applying for coverage because:

☐ I am covered by another employer group benefit plan (please list) _____
☐ My dependents are covered by another employer group benefit plan (please list) _____
☐ I am covered by an individual benefit plan (please list) _____
☐ Other reason (please explain) _____

AUTHORIZATION TO RELEASE INFORMATION TO AVERA HEALTH PLANS

By signing this application, I authorize any consumer reporting agency, medical information bureau, insurance company, or other person having information about me or my dependents to release to Avera Health Plans or any of its designees any and all records or information pertaining to medical history, health history questions, health statement or health services rendered to me or my dependents, including drug and/or alcohol abuse information, or any information regarding responsibility for payment to Avera Health Plans for any administrative purpose.

I also authorize Avera Health Plans, its employees and agents, to disclose records and information as permitted by law to authorized persons including other insurers or reinsurers, vendors of employee insurance or cafeteria plans. Avera Health Plans may be compensated by other insurers or vendors. A copy of this authorization is as valid as the original. Unless otherwise stated or revoked by my written revocation, this authorization terminates when enrollment in Avera Health Plans terminates. This information will be used to determine eligibility for benefits, payment responsibility and utilization review. I agree to abide by the documents describing my coverage, (including but not limited to the Certificate of Coverage, Member Handbook and Benefit Summary, the Evidence of Coverage and Summary Plan Document) and to pay any applicable premiums, co-payments, coinsurance and deductibles. I understand that my enrollment or eligibility for benefits in Avera Health Plans is conditional upon me signing this authorization and that failure to sign may result in being denied enrollment or benefits.

Subscriber's Signature: _____ Date: _____

Employer's Representative Signature (Required):_____ Date:_____

OTHER INSURANCE INFORMATION

If you have other health insurance, we will coordinate your benefits with your other health insurance. Have you, your spouse or any of your dependent children been covered by any other group, medical, hospital or surgical insurance, including Medicare, Medicaid or Medicare Disability? ☐ YES ☐ NO

Insurance Carrier: _____ Phone: _____ Policy Number: _____

If you checked YES, please attach a Certificate of Creditable Coverage for yourself and each dependent covered by the prior carrier.

Effective Date: _____ Termination Date: _____

Will this coverage end before the Avera Health Plans effective date? ☐ YES ☐ NO

Type of Coverage with Prior Carrier: ☐ Single ☐ Family ☐ Employee/Child(ren) ☐ Employee/Spouse

HEALTH HISTORY QUESTIONS

To better serve you, please complete the following. In the last five years, has any person on the application for health insurance ever had or ever been treated or diagnosed by a physician or a medical professional for:

☐ YES ☐ NO Lung conditions (For example: chronic lung disease, cystic fibrosis, allergies or asthma)
☐ YES ☐ NO Bone, joint, muscle conditions (For example: arthritis, fractures, joint replacement, osteoporosis or chronic back pain)
☐ YES ☐ NO Cancer
☐ YES ☐ NO Stomach and/or bowel conditions (For example: Crohn's disease, pancreatitis, heartburn, ulcers, colitis)
☐ YES ☐ NO Congenital disease or disorders
☐ YES ☐ NO Endocrine conditions (For example: thyroid, diabetes)
☐ YES ☐ NO Drug or alcohol abuse
☐ YES ☐ NO Heart disorders or illness (For example: high blood pressure, heart attack, chest pain, stroke, heart disease or congestive heart failure)
☐ YES ☐ NO Blood disorders (For example: HIV/AIDS, hepatitis or hemophilia)
☐ YES ☐ NO Mental health issues
☐ YES ☐ NO Are you currently pregnant? If Yes, how many weeks gestation are you? ___ weeks
Are you high risk? ☐ YES ☐ NO
Are you having multiple babies? ☐ YES ☐ NO
Have you had or are you having pre-term labor? ☐ YES ☐ NO
☐ YES ☐ NO Is there an auto accident or Workers' Compensation case pending?
☐ YES ☐ NO Are there any other conditions, disorders, illnesses or diseases for which further diagnostic tests, consultations, observation, treatment or surgery or hospitalization has been recommended?

HEALTH STATEMENT (If you checked **YES** to any of the health questions on this form, please complete this section.)

Name of Person	Name of Condition	Dates and Duration of Treatment	Type of Treatment	Indicate Degree of Recovery Partial – Half – ¾ – Full
				☐25% ☐50% ☐75% ☐100%
				☐25% ☐50% ☐75% ☐100%
				☐25% ☐50% ☐75% ☐100%
				☐25% ☐50% ☐75% ☐100%
				☐25% ☐50% ☐75% ☐100%

Please list all current medications: _____

_____

Information provided will be reviewed by Avera Health Plans Medical Management.

☐ I am sending additional medical information to:
Avera Health Plans Medical Management, 3816 S Elmwood Ave., Suite 100, Sioux Falls, SD 57105-6538.

If you commit fraud or intentionally misrepresent your answers on this application, Avera Health Plans has the right to rescind your policy.

➢ Your initials below verify that you have read and understand the enclosed statements and acknowledge that all the information on this form is complete and true.

Initial: _____ Date: _____

INTERNAL USE ONLY	
Underwriting Initials	Score

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