1570 Midway Pl.
Menasha, WI 54952
Fax: 920-720-1904

Membership Application and Change Form

Name of Employer: _____ Date of Full-Time Employment: _____

Group # /Rate Code: _____ Effective Date/Date of Change: _____

Coverage	Reason for Application/Change		
☐ HMO	☐ New Subscriber	☐ Address Change	**Give addition/change explanations here:**
☐ POS	☐ Add Dependent	☐ Benefit Plan Change	Dependent addition reason:
☐ NationCare	☐ Termination	☐ COBRA/Continuation	Termination reason:
☐ Network Options	☐ Dependent Termination	☐ Open Enrollment	Dependent termination reason:
☐ Other	☐ Name Change	☐ Waiver of Insurance	Other:

Employee Information

Last Name:	Legal First Name:	Nickname:	MI:	**Status (check)**	
Address/Apt. #:				☐ Single	☐ Married
City:	State:	Zip:		☐ Hourly	☐ Salary
Home Phone:		Work Phone:		☐ Union	☐ Non-union

Enrollment Section (attach additional sheets of paper if necessary)

	Name (Last, First, MI) / SSN #	Birth date mm/dd/yr	Sex	Disabled	Relationship	Name of Personal Doctor (Strongly recommended)	Current Patient?
Self	SSN #		☐ M ☐ F	☐ Yes ☐ No	Self		☐ Yes ☐ No
Sp.	SSN #		☐ M ☐ F	☐ Yes ☐ No	Spouse		☐ Yes ☐ No
Dep 1	SSN #		☐ M ☐ F	☐ Yes ☐ No	☐ Child ☐ Stepchild ☐ Grandchild ☐ Guardianship		☐ Yes ☐ No
Dep 2	SSN #		☐ M ☐ F	☐ Yes ☐ No	☐ Child ☐ Stepchild ☐ Grandchild ☐ Guardianship		☐ Yes ☐ No
Dep 3	SSN #		☐ M ☐ F	☐ Yes ☐ No	☐ Child ☐ Stepchild ☐ Grandchild ☐ Guardianship		☐ Yes ☐ No

Network Health Plan (NHP) and/or Network Health Insurance Corporation (NHIC), as applicable, requires all legal paperwork for insuring dependents involving guardianship and adoption.

Visit *networkhealth.com* for an online Provider Directory to choose a primary care practitioner for yourself and dependents.

Other Insurance Coverage Information

Do you or any dependents have other group medical insurance including Medicare? ☐ Yes ☐ No

If Yes, does this other policy include pharmacy coverage? ☐ Yes ☐ No

Will this insurance continue after Network Health Plan begins? ☐ Yes ☐ No

Individuals who have other coverage: Policyholder:

Name of insurance company: Policy #:

Is there a divorce decree establishing insurance responsibility? ☐ Yes ☐ No

Name of responsible party: _____ Date of birth: _____

Please provide Network Health Plan with a copy of the portion of the decree which states this responsibility.

Over for signature →

Confidentiality Statement

In completing this application, I authorize any health care provider to release any of my medical information, including those records pertaining to the testing and treatment of mental health, alcohol and/or substance abuse, and HIV infection, to Network Health Plan and/or Network Health Insurance Corporation's medical and claims management personnel, when reasonably related to my application for coverage through NHP and/or NHIC, as applicable. (By signing this authorization as the Employee or Spouse, you also authorize the release of medical information for any covered minor dependents and/or any covered dependents for which you have legal guardianship.)

I also authorize any health care provider to release any and all of my medical records to NHP and/or NHIC, as applicable, when reasonably related to coverage for quality measurement or administrative purposes. This authorization is valid while my coverage is in effect or for as long as a claim is pending, whichever is longer. I understand I am entitled to inspect and obtain a copy of the released records and that I may revoke these authorizations at any time except to the extent that a health-care provider has already acted in reliance upon them. I also understand that I am (or my authorized representative is) entitled to receive a copy of this complete form. By signing this form, I authorize NHP and/or NHIC, as applicable, to release this information for a period not to exceed 30 months from the date this application is signed.

If any law or provider requires an additional authorization for the release of medical records, I will be required to sign a special consent for the release of this information. I understand that NHP and/or NHIC, as applicable, will make every effort to protect my privacy at all times, and that member-identifiable information will not be shared with my employer unless authorized by "me", the member.

I understand that failure to authorize the release of medical information to NHP and/or NHIC, as applicable, may cause significant delays in the processing of my claims. I also understand that NHP and/or NHIC retain(s) the right to release claim information received from health care providers to NHP and/or NHIC, as applicable, contracted entities to accomplish its obligations under the group contract.

All information furnished by me on this application is true and complete to the best of my knowledge.

Employee signature is not required in a cancellation due to termination but must be signed by the employer.

Employee Signature	Date	Employer Signature	Date

Network Health Plan and/or Network Health Insurance Corporation Internal Use Only:

Effective Date	Entered By	Date

HMO plans underwritten by Network Health Plan. POS plans underwritten by Network Health Insurance Corporation, or Network Health Insurance Corporation and Network Health Plan.

Fax this completed / signed form to: 920-720-1904

Nondiscrimination

Network Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Network Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Network Health:

- 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 Network Health's discrimination complaints coordinator at 800-826-0940.

If you believe that Network Health 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 Network Health's discrimination complaints coordinator, 1570 Midway Place, Menasha, WI 54952, phone number 800-826-0940, TTY 800-947-3529, Fax 920-720-1907, compliance@networkhealth.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Network Health's discrimination complaints coordinator is available to help you. 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 **https://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, 1-800-368-1019, 800-537-7697 (TDD).

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

Multi-language Interpreter Services

If you, or someone you're helping, has questions about Network Health, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 800-826-0940.

Spanish: Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Network Health, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 800-826-0940.

Hmong: Yog koj, los yog tej tus neeg uas koj pab ntawd, muaj lus nug txog Network Health, koj muaj cai kom lawv muab cov ntshiab lus qhia uas tau muab sau ua koj hom lus pub dawb rau koj. Yog koj xav nrog ib tug neeg txhais lus tham, hu rau 800-826-0940.

Chinese: 如果您，或是您正在協助的對象，有關於[插入SBM項目的名稱 Network Health 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字800-826-0940.

German: Falls Sie oder jemand, dem Sie helfen, Fragen zum Network Health haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 800-826-0940 an.

Arabic:
إذا كان لديك أو لدى شخص كنت مساعدة، أسئلة حول Health Network، لديك الحق في الحصول على المساعدة والمعلومات باللغة الخاصة بك دون أي تكلفة. للتحدث مع مترجم فوري، قم باستدعاء 800-826-0940.

Russian: Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Network Health, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 800-826-0940.

Korean: 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Network Health 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는800-826-0940.로 전화하십시오.

Vietnamese: Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Network Health, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 800-826-0940.

Pennsylvania Dutch: “Wann du hoscht en Froog, odder ebber, wu du helfscht, hot en Froog baut Network Health, hoscht du es Recht fer Hilf un Information in deinre eegne Schprooch griege, un die Hilf koschtet nix. Wann du mit me Interpreter schwetze witt, kannscht du 800-826-0940 uffrufe.

Laotian: ຖ້າທ່ານ, ຫຼື ຄົນທ່ ທ່ານກໍ າລັ ງຊ່ ວຍເຫຼ ອ, ມ ີຄ ຳຖ ຳມກ ່ ຽວກ ັ ບ Network Health, ທ ່ ານມ ີສ ດທ ່ ຈ ະໄດ ້ ຮ ັ ບການຊ ່ ວຍເຫຼ ອ ແລະຂ ໍ ້ ມ ູ ນຂ ່ າວສ ານທ ່ ເປ ັ ນພ າສ າຂ ອງທ ່ ານ ບ ໍ ມ ີ ຄ ່ າ ໃ ຊ ້ จ ่ าย. ການ ໂ ອ ້ ລ ົ ມ ກ ັ ບ ນ ายພ าสา, ให ้ โ ทหา 800-826-0940.

French: Si vous, ou quelqu'un que vous êtes en train d’aider, a des questions à propos de Network Health, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 800-826-0940.

Polish: Jeśli Ty lub osoba, której pomagasz ,macie pytania odnośnie Network Health, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku .Aby porozmawiać z tłumaczem, zadzwoń pod numer 800-826-0940.

Hindi: यिद आप**,** या ि◌कसी को आप की मदद कर रहे ह◌**,** के बारे म◌ सवाल हैNetwork Health, आप कोई भी कीमत पर अपनी भाषा म◌ मदद और जानकारी प्रा◌ात करने का अिधकार है। एक दुभा◌िषया के ि◌लए बात करने के ि◌लए, 800-826-0940 कहते ह◌।.

Albanian: Nëse ju, ose dikush që po ndihmoni, ka pyetje për Network Health, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin 800-826-0940.

Tagalog: Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Network Health, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 800-826-0940.