GUNDERSEN HEALTH PLAN

Effective Date: _____
Group Number:_____
ID Number: _____
For Office Use Only

**Gundersen Health Plan, Inc.**
**1900 South Avenue, La Crosse, WI 54601**
**Phone: 608-775-8092 or 855-685-6404 – Group Administration Fax: 608-775-8060**

# ENROLLMENT AND CHANGE APPLICATION

## Election Information

Elected Benefit Plan: _____

Initial Enrollment ☐ Annual Election Enrollment ☐ Special Election Period ☐ Date of Event: _____

☐ **If you are electing coverage due to a loss of other coverage it must have been involuntary. By checking the box you are confirming that your loss of coverage was involuntary.**

Coverage Electing: Self ☐ Self/Spouse ☐ Self/Children ☐ Self/Spouse/Children ☐

## Employee Information

| | | | |
|---|---|---|---|
| Employer Name: | | Division: | Hourly ☐ Salaried ☐ |
| Employee Last Name: | | First Name: | MI: |
| Date of Birth: | | SSN: | Male ☐ Female ☐ |
| Street Address: | | City: | State: |
| County: | Zip: | Email: | Home Phone: Cell Phone: |
| Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Other_____ | | | |
| Occupation: | | Hours Worked Per Week: | Date Employed Fulltime: |

☐ Check this box if the eligible grandchildren listed below reside with and are financially dependent upon you.

| Last Name, First Name | Relationship | Sex | Date of Birth | SS# |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Your Social Security number is requested for IRA tax reporting requirements regarding your health plan. It does not have any impact on you application or enrollment.

CE 2017 EC App
Revised: 9/15/2016
WI OCI Approval Date Small Group: 9/16/2016 IA Approval Date: 9/28/2016 MN Approval Date: 10/27/2016
WI OCI Approval Date Large Group: 9/15/2016

## Medicare Other Coverage Information

Are you or your dependents receiving coverage from Medicare? Yes No

If yes, list the individual's name, effective date of Medicare coverage, and Medicare number: _____
_____

If yes, do you have other insurance coverage for pharmacy benefits? Yes No

If yes, provide the pharmacy carrier's name and effective date of plan:_____

## Waiver of Coverage

You may decline health coverage offered by your employer. This is called a waiver of coverage. If you waive coverage for yourself, you may not cover dependents under the Employer's health plan.

If you decline coverage considered affordable and minimum essential under the Patient Protection and Affordable Care Act ("ACA"), you will not qualify for government credits and subsidies to purchase individual health insurance on the Marketplace.

The decision to waive coverage has consequences for you. For example:

- If you refuse the offer of the Employer's health coverage and do not obtain coverage on your own, you may be subject to a penalty.
- If you waive coverage, you have an option to enroll again only as described in the Certificate of Coverage.

I acknowledge that my employer offered me affordable minimum essential coverage, as defined under the ACA. I have read the above and I understand the consequences of my waiver of coverage.

I am waiving coverage for:

Self ☐ Spouse ☐ Children ☐ please list:_____

I am waiving group health insurance because:

☐ The excluded individual(s) will be covered under another plan that is not sponsored by my employer.

☐ Other reason for waiving: _____

## Notice of Enrollment Rights

If you are declining enrollment for yourself or your dependents (including spouse), you may in the future, be able to enroll yourself or your dependents in this plan:

- Under a Special Election Enrollment Period as defined in the Certificate of Coverage
- During the Annual Open Enrollment Period

Contact your employer to determine if you are eligible to enroll and to complete the required forms to enroll for coverage. Your application must be received within 30 days of your eligibility date.

## Dental Disclaimer

This policy does not include pediatric dental services, which is an essential health benefit under the Affordable Care Act. This dental coverage is available in the insurance market as a stand-alone dental product. Please contact your insurance carrier, agent, Federally Facilitated Marketplace, or state-based Health Care Exchange if you wish to purchase pediatric

dental coverage or a stand-alone dental product. By signing this application you are acknowledging this policy does not contain pediatric dental.

**Statements of Understanding & Acknowledgement**

- I understand that health information about me provided to Gundersen Health Plan is protected by federal privacy regulations and that Gundersen Health Plan will only use and disclose such information as described in its Notice of Privacy Practices.

- I understand that information that is used or disclosed to an entity that is not subject to federal privacy laws may be re-disclosed by the recipient and is no longer protected under federal law.

- I understand that I may revoke this authorization in writing at any time, prior to the disclosure of this information. Submit revocations to: Gundersen Health Plan, Attention Group Administration, 1900 South Avenue, Mail Stop: NCA2-01, La Crosse, Wisconsin 54601. I also understand that the revocation of this authorization will not affect uses and disclosures of my health information for purposes of treatment, payment and business operations, including agent commission statements.

- Upon request, I understand that I am entitled to receive a copy of this signed authorization.

- This authorization shall be valid during the entire time I am covered under health insurance coverage issued by Gundersen Health Plan.

- A copy of this authorization shall be as valid as the original.

- Medical records and information may be disclosed prior to and after the date of this authorization.

| Your Signature (If signed by your personal representative, please indicate authority). | Date of Birth | Date Signed |
|---|---|---|
| Spouse's Signature (required if married) | Date of Birth | Date Signed |
| Dependents Signature (required if age 18 or older) | Date of Birth | Date Signed |
| Dependents Signature (required if age 18 or older) | Date of Birth | Date Signed |

**For help to translate or understand this, please call (800) 897-1923, TTY 711 or toll free (800) 877-8973.**

**Spanish** – Este aviso contiene información importante. Este aviso contiene información importante acerca de su solicitud o cobertura a través de Gundersen Health Plan. Preste atención a las fechas clave que contiene este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica u obtener ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al (800) 897-1923. TTY (800) 877-8973.

**Hmong** – Tsab ntawv tshaj xo no muaj cov ntshiab lus tseem ceeb. Tsab ntawv tshaj xo no muaj cov ntsiab lus tseem ceeb txog koj daim ntawv thov kev pab los yog cov kev pab kam them nqi kho mob los ntawm Gundersen Health Plan. Saib cov caij nyoog ceeb hauv daim ntawv no. Tej zaum koj kuj yuav tau ua qee yam kom tsis pub dhau cov caij nyoog koj thiaj yuav tau txais kev pab kam them nqi kho mob los yog kev pab them tej nqi kho mob. Koj muaj cai tau cov ntshiab lus no thiab tau kev pab ua koj hom lus pub dawb rau koj. Hu rau (800) 897-1923. TTY (800) 877-8973.

**German** – Diese Benachrichtigung enthält wichtige Informationen. Diese Benachrichtigung enthält wichtige Informationen bezüglich Ihres Antrags oder Ihres Krankenversicherungsschutz durch Gundersen Health Plan. Suchen Sie nach wichtigen Terminen in dieser Benachrichtigung. Sie könnten bis zu bestimmten Stichtagen handeln müssen, um Ihren Krankenversicherungsschutz oder Hilfe mit den Kosten zu erhalten. Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Rufen Sie an unter (800) 897-1923. TTY (800) 877-8973.

**Chinese** – 本通知含有重要的訊息。本通知包含了關于您通過Gundersen Health Plan提交之申請或保險責任範圍的重要訊息。請留意本通知內的重要日期。您可能需要在若幹截止日期之前采取行動，以維持您的健康保險責任範圍或者費用補貼。您有權利免費獲得以您母語撰寫的本訊息和各種幫助。請致電 (800) 897-1923。聾啞人電話：TTY (800) 877-8973。

**French** – Cet avis contient des informations importantes. Cet avis contient des informations importantes concernant votre demande ou sur la prise en charge par Gundersen Health Plan. Rechercher les dates importantes sur le présent avis. Il se peut qu'une action de votre part soit nécessaire avant une certaine date afin de conserver votre couverture santé ou votre aide sur les frais. Vous avez le droit d'obtenir gratuitement ces informations et une assistance dans votre langue. Appelez le (800) 897-1923. TTY (800) 877-8973.

**Vietnamese** – Thông báo này cung cấp thông tin quan trọng. Thông báo này có thông tin quan trọng bàn về đơn nộp hoặc hợp đồng bảo hiểm qua chương trình Gundersen Health Plan. Xin xem ngày then chốt trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng trong thời hạn để duy trì bảo hiểm sức khỏe hoặc được trợ trúp thêm về chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình miễn phí. Xin gọi số (800) 897-1923. TTY (800) 877-8973.

**Arabic** – يحوي هذا الاشعار معلومات هامة. يحوي هذا الاشعار معلومات مهمة بخصوص طلبك للحصول على التغطية من خلال Gundersen Health Plan.
ابحث عن التواريخ الهامة في هذا الاشعار. قد تحتاج لاتخاذ اجراء في تواريخ معينة للحفاظ على تغطيتك الصحية أو للمساعدة في دفع التكاليف.
لك الحق في الحصول على المعلومات والمساعدة بلغتك من دون أي تكلفة. اتصل ب 1923-897 (800). 877-8973 (800) TTY.

**Russian** – Настоящее уведомление содержит важную информацию. Это уведомление содержит важную информацию о вашем заявлении или страховом покрытии через Gundersen Health Plan. Посмотрите на ключевые даты в настоящем уведомлении. Вам, возможно, потребуется принять меры к определенным предельным срокам для сохранения страхового покрытия или помощи с расходами. Вы имеете право на бесплатное получение этой информации и помощь на вашем языке. Звоните по телефону (800) 897-1923. TTY (800) 877-8973.

**Laotian** – ແຈ້ງການນີ້ມີຂໍ້ມູນສຳຄັນ. ແຈ້ງການນີ້ມີຂໍ້ມູນທີ່ສຳຄັນກ່ຽວກັບການສະໝັກຂໍ ຫຼື ການຄຸ້ມຄອງຂອງທ່ານ ໂດຍຜ່ານ Gundersen Health Plan. ໃຫ້ເບິ່ງການສຳນຶດວັນທີສຳຄັນຢູ່ໃນແຈ້ງການນີ້. ທ່ານອາດຈະຕ້ອງໄດ້ໃຊ້ເວລາດຳເນີນການຕາມກຳນົດເວລາທີ່ແນ່ນອນ ເພື່ອຮັກສາການຄຸ້ມຄອງຂອງທ່ານ ຫຼື ການຊ່ວຍເຫຼືອທີ່ມີຄ່າໃຊ້ຈ່າຍ. ທ່ານມີສິດໄດ້ຮັບຂໍ້ມູນຂ່າວສານ ແລະ ການຊ່ວຍເຫຼືອເປັນພາສາຂອງທ່ານ ໂດຍບໍ່ເສຍຄ່າໃຊ້ຈ່າຍໃດໆ. ໃຫ້ໂທຫາເບີ (800) 897-1923. TTY (800) 877-8973.

**Hindi** – इस नोटिस में महत्वपूर्ण जानकारी है। इस नोटिस में आपके आवेदन या Gundersen Health Plan के माध्यम से बीमे के कवरेज बारे में महत्वपूर्ण जानकारी है। इस नोटिस में मुख्य तारीखें देखें। अपना स्वास्थ्य बीमा बनाए रखने या कीमत चुकाकर सहायता प्राप्त करने के लिए आपको कुछ निश्चित समयसीमा तक कार्रवाई करने की ज़रूरत हो सकती है। आपको कोई कीमत चुकाए बिना यह जानकारी और सहायता अपनी भाषा में प्राप्त करने का अधिकार है। कॉल करें (800) 897-1923 । TTY (800) 877-8973.

**Korean** – 본 통지서에는 중요한 정보가 들어 있습니다. 본 통지서에는 귀하의 신청 또는 Gundersen Health Plan를 통한 보험보장에 관한 중요한 정보가 들어 있습니다. 본 통지서에 나와있는 중요한 날짜를 찾아보십시오. 귀하는 귀하의 건강 보험보장을 유지하기 위해 특정 마감일까지 조치를 취해야 할 수도 있거나, 비용에 관한 도움이 필요할 수도 있습니다. 귀하는 귀하가 사용하는 언어로 이러한 정보와 도움을 무료로 받을 권리가 있습니다. (800) 897-1923 번으로 전화하십시오.TTY (800) 877-8973.

**Tagalog** – Ang Abisong ito ay may Importanteng Impormasyon. Ang abisong ito ay may importanteng impormasyon tungkol sa aplikasyon o proteksiyon mo sa pamamagitan ng Gundersen Health Plan. Hanapin ang mga pangunahing petsa na nasa abisong ito. Maaaring kailangan mong kumilos bago sumapit ang ilang takdang araw para mapanatili ang proteksiyon ng kalusugan mo o para makatulong sa mga gastusin. Karapatan mong makuha ang impormasyon na ito na nasa wika mo nang walang gastos. Tumawag sa numerong (800) 897-1923. TTY (800) 877-8973.

**Pennysylvanian Dutch** – Die Bekanntmaching gebt wichdichi Auskunft. Die Bekanntmaching gebt wichdichi Auskunft baut dei Application oder Coverage mit Gundersen Health Plan. Geb Acht fer wichdiche Daadem in die Bekanntmachung. Es iss meeglich, ass du ebbes duh muscht, an beschtimmde Deadlines, so ass du dei Health Coverage bhalde kannscht, odder bezaahle helfe kannscht. Du hoscht es Recht fer die Information un Hilf in deinre eegne Schprooch griege, un die Hilf koschtet nix. Wann du mit me Interpreter schwetze witt, kannscht du (800) 897-1923 uffrufe.

**Amharic** – ይህ ማስታወቂያ አስፈላጊ መረጃ ይዟል። ይህ ማስታወቂያ ስለ ማመልከቻዎ ወይም የ Gundersen Health Plan ሽፋን አስፈላጊ መረጃ አለው። በዚህ ማስታወቂያ ውስጥ ቁልፍ ቀኖችን ፈልጉ። የጤናን ሽፋንዎን ለመጠበቅና በአከፋፈል እርዳታ ለማግኘት በተውሰኑ የጊዜ ገደቦች እርምጃ መውሰድ ይጠበቅት ይሆናል። ይህን መረጃ እንዲያገኙ እና ያለምንም ክፍያ በቋንቋዎ እርዳታ እንዲያገኙ መብት አለዎት። (800) 897-1923. TTY (800) 877-8973. ይደውሉ።

Serbocroatian – U ovom obavještenju su sadržane važne informacije. U ovom obavještenju su sadržane važne informacije o Vašoj prijavi ili osiguranju preko Gundersen Health Plan. Pogledajte nalaze li se u ovom obavještenju neki ključni datumi. Možda ćete morati poduzeti određenje radnje u datom roku kako biste i dalje zadržali svoje osiguranje ili pomoć pri plaćanju. Imate pravo da ove informacije, kao i pomoć, dobijete besplatno na svom jeziku. Nazovite (800) 897-1923. TTY (800) 877-8973.

Gundersen Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity, sexual orientation or health status.

Gundersen Health Plan –

- 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 interpreter
  - Information written in other languages

If you need these services, contact Gundersen Health Plan Customer Service at (800) 897-1923.

If you believe that Gundersen Health Plan 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 –

Kelly Skifton, Compliance Officer; 1900 South Avenue, Mailstop NCA2-01, La Crosse WI 54601
Phone: (800) 897-1923 ext 58052; TTY number: 711 or toll free (800) 877-8973; Fax: (608) 775-8060
Email: hpmemberadvocates@gundersenhealth.org

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, Kelly Skifton, Compliance Officer, 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 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, D.C. 20201
(800) 368-1019; (800) 537-7697 (TDD)

Complaint forms are available at hhs.gov/ocr/office/file/index.html.