ASURIS NORTHWEST HEALTH

Asuris Northwest Health
528 East Spokane Falls Boulevard
Suite 301
Spokane, WA 99202
Mail form to: PO Box 1271
Portland, OR 97207-1271
Fax to: 1-866-303-5117

Application For Enrollment/Change (for groups 1-50)

Please print in black or blue ink. Incomplete and/or illegible information may result in delayed coverage. If an item is not applicable, write "N/A." **The form must be signed and dated or it will be returned.** The five boxes directly below should be completed by the Group Administrator.

Health Group Number	Subgroup	Class	Group Name	Requested Effective Date
				(mm/dd/yyyy)

Employee Last Name	First Name	Middle Initial

SECTION 1 - NEW ENROLLMENT, CHANGE OR CANCELLATION

NEW ENROLLMENT

New Enrollment due to:
☐ New Group ☐ Open Enrollment ☐ New Hire ☐ Rehire-Date _____ (mm/dd/yyyy)

CHANGE

Change:
☐ Add employee with/without dependent(s) ☐ Add dependent(s) only-Employee must already be enrolled ☐ Plan Selection

Change due to:
☐ Birth ☐ Marriage ☐ Adoption ☐ Open Enrollment ☐ COBRA Coverage Exhausted
☐ Loss of Eligibility on another plan ☐ Court Order ☐ Add Eligible Domestic Partner

Date of Change Event
(mm/dd/yyyy)

Demographic Information Change:
☐ Name Change ☐ Address Change

CANCELLATION AND/OR COBRA OR NON-COBRA CONTINUATION ENROLLMENT

Cancellation: (select cancellation reason and enter cancellation date below)
☐ Cancel Employee and All Dependent(s) ☐ Cancel All Dependent(s)
☐ Cancel Dependent(s) - List: _____

Group Administrator signature is required below if cancellation is being requested with an effective date prior to the date this form will be received by Asuris Northwest Health.

COBRA or Non-COBRA Continuation Enrollment:
☐ COBRA ☐ Non-COBRA Continuation

Cancellation Reason/COBRA or Non-COBRA Continuation Qualifying Event:
☐ Dependent no longer eligible ☐ Death ☐ Medicare Entitlement ☐ Military Leave
☐ Divorce, annulment, or termination of Domestic Partnership ☐ Reduction of Hours
☐ Termination of Employment ☐ Other Medical Coverage ☐ Other reason _____

Date of Cancellation Event
(mm/dd/yyyy)

This confirms that any employee and/or dependent being cancelled on this form did not have an expectation of coverage after the cancellation effective date and paid no premium after the cancellation effective date.

Group Administrator Signature _____ **Date** _____ (mm/dd/yyyy)

SECTION 2 - PLAN SELECTION

Medical Plan Choices			Pharmacy	Additional Benefits
Asuris Group Direct ☐ Asuris Group Direct Gold ☐ Asuris Group Direct Gold+ ☐ Asuris Group Direct Platinum ☐ Asuris Group Direct Platinum+	**Asuris Group Direct Silver** ☐ Asuris Group Direct Silver	**Asuris Group Direct HSA** ☐ Asuris Group Direct Bronze HSA+ ☐ Asuris Group Direct Silver HSA	Embedded with Medical Plan	☐ Adult Vision ☐ Employee Asst Program (EAP) ☐ Unlimited Spinal Manipulation

If your Employer offers multiple medical products with the same name, please provide the information located in your Summary of Benefits and Coverage.

DENTAL: ☐ Aspire ☐ Enhance ☐ No Dental

SECTION 3 - EMPLOYEE INFORMATION

Last Name	First Name	Middle Initial

Mailing Address	City, State, and ZIP Code

Physical Address	City, State, and ZIP Code

Daytime Telephone Number	E-mail Address	Primary Language
(xxx) xxx-xxxx	Email address	

Date of Birth (mm/dd/yyyy)	Gender: ☐ Female ☐ Male	Social Security Number	Original Date of Hire (mm/dd/yyyy)

Full-time Date of Hire (mm/dd/yyyy)	Hours Per Week	Marital Status: ☐ Single ☐ Divorced ☐ Married or Registered Domestic Partner ☐ Non-Registered Domestic Partner*

What type of member card would you like to receive?
☐ Family Level Card (all members listed on the same card) ☐ Member Level Card (each member on a separate card)

*** Non-Registered Domestic Partners must submit an Affidavit of Domestic Partnership.**

SECTION 4 - ENROLLING DEPENDENTS

Gender	Name(s) of Individual(s) to be Covered (First, Middle, Last)	Medical	Dental	Relationship to Applicant	Social Security Number for each Individual Covered	Birthdate Mo/Day/Yr
☐ F ☐ M		☐	☐			(mm/dd/yyyy)
☐ F ☐ M		☐	☐			(mm/dd/yyyy)
☐ F ☐ M		☐	☐			(mm/dd/yyyy)
☐ F ☐ M		☐	☐			(mm/dd/yyyy)

If you need extra space, please request an additional form from your group administrator.

Is any child listed on this application eligible for other group coverage through his/her employer?

☐ **No** ☐ **Yes If yes, list child's name:** _____

Is any child listed on this application eligible for other group coverage through his/her spouse's employer?

☐ **No** ☐ **Yes If yes, list child's name:** _____

SECTION 5 - CHILD CUSTODY INFORMATION

If you and your spouse are divorced or legally separated, please indicate below who has Legal custody of your child(ren):

Name of Child(ren)	Father	Mother	Joint	Other	Date awarded	Is the parent without custody required by court decree to provide coverage for the children? Yes	No	If "Yes" list other coverage provided
_____	☐	☐	☐	☐	(mm/dd/yyyy)	☐	☐	_____
_____	☐	☐	☐	☐	(mm/dd/yyyy)	☐	☐	_____
_____	☐	☐	☐	☐	(mm/dd/yyyy)	☐	☐	_____

SECTION 6 - CURRENT/PRIOR COVERAGE INFORMATION

Please indicate for EACH person listed on this application any health insurance coverage (including Medicare or Medicaid) currently in effect prior to the proposed effective date of this coverage. Each person applying for coverage must be listed below. If no health insurance coverage is in effect, please indicate NONE.

Applicant's Name	Insurance Carrier, Policy Number and Phone Number	Date of Coverage Month/Day/Year		Will coverage continue?	Type of Coverage	Type of Product
1.		**From**	**To**	☐ Yes ☐ No	☐ Group ☐ Individual	☐ Medical ☐ Dental
2.		**From**	**To**	☐ Yes ☐ No	☐ Group ☐ Individual	☐ Medical ☐ Dental
3.		**From**	**To**	☐ Yes ☐ No	☐ Group ☐ Individual	☐ Medical ☐ Dental
4.		**From**	**To**	☐ Yes ☐ No	☐ Group ☐ Individual	☐ Medical ☐ Dental
5.		**From**	**To**	☐ Yes ☐ No	☐ Group ☐ Individual	☐ Medical ☐ Dental

MEDICARE: If you or any family members listed on this application have Medicare, please complete the following information:

Enrolling Individual	Effective Date (mm/dd/yyyy)	Medicare Number (please include alpha prefix)	Coverage Type (Check all that apply)
			☐ Part A ☐ Part B ☐ Part D

Reason for Medicare Entitlement: ☐ Age ☐ Disability ☐ Dual Entitlement ☐ ESRD

Enrolling Individual	Effective Date (mm/dd/yyyy)	Medicare Number (please include alpha prefix)	Coverage Type (Check all that apply)
			☐ Part A ☐ Part B ☐ Part D

Reason for Medicare Entitlement: ☐ Age ☐ Disability ☐ Dual Entitlement ☐ ESRD

If you need extra space, please request an additional form from your group administrator.

SECTION 7 - TOBACCO ABSTINENCE CERTIFICATION STATEMENT

A surcharge is applied to the regular Periodic Rate for an enrolled individual who is Tobacco User, unless he or she is enrolled in a wellness program designed to prevent or reduce tobacco use. A Tobacco User is a person who may legally use tobacco and has used tobacco (in any form, but excluding any religious or ceremonial use) on average four or more times per week within the last six months.

By my signature below, I certify that:

☐ I am not a Tobacco User.

☐ Although a Tobacco User, I am currently enrolled in, and (unless I cease to be a Tobacco User) will remain enrolled in, a wellness program designed to prevent or reduce tobacco use throughout the period I am enrolled in coverage at the regular Periodic Rate without tobacco surcharge.

PLEASE NOTE: An individual who has signed a tobacco abstinence certification statement and who subsequently becomes a Tobacco User or ceases wellness program enrollment (except due to ceasing to be a Tobacco User) must notify the Company immediately, and the surcharge then will apply to him or her. If false information about tobacco use or wellness program enrollment is submitted or if you fail to notify the Company when changes in your tobacco use or wellness program participation would subject you to the tobacco surcharge, the Company reserves the right to take any action available to it, including action to collect unpaid surcharge amounts and/or other damages.

Member Name	Member Name	Member Name
(mm/dd/yyyy)	(mm/dd/yyyy)	(mm/dd/yyyy)
Date	Date	Date

SECTION 8 - CONSENT TO ELECTRONIC DISTRIBUTION

Asuris Northwest Health (Asuris) is engaged in efforts to increase the use of technology and curb the use of paper. In support of those efforts, Asuris has established a process under which communications to members can be posted to a secured account that a member establishes on myAsuris.com, with e-mail notice provided to a member-supplied e-mail account when a new communication is posted.

By my signature below and unless I have expressly rejected electronic distribution by marking the checkbox below, I consent, on behalf of myself and any covered dependents, to the electronic distribution of communications related to the coverage applied for and understand that:

- To access electronically distributed communications, I and each of my covered dependents will need to establish myAsuris.com accounts for use on a system meeting the outlined requirements and I represent that we each have and will continue to have access to such a system or systems.
- Not all member communications are currently available electronically, but agree that my consent will apply to the following materials available, or as they become available, for electronic distribution, (i) notices of enrollment and/or effective date, (ii) acknowledgements of receipt of claims, requests for additional information related to claims and notices of associated delays in processing, and determinations on submitted claims, (iii) general informational disclosures required by law, including but not limited to notices of rights under the Women's Health and Cancer Rights Act, state patient protection acts, and privacy laws, (iv) communications regarding complaints, grievances, or appeals, including but not limited to acknowledgements of receipt, requests for additional information and notices of associated delays, and notices of determinations, (v) summaries of benefits and coverage and uniform glossary of terms, (vi) notices of benefit changes or policy modifications, (vii) renewal information, (viii) notices of discontinuation, (ix) notices of termination and continuation coverage rights, (x) certificates of creditable coverage, (xi) billing notices and statements.
- Until a type of communication can be distributed electronically, a paper copy will be provided.
- Once available in electronic form, any electronically distributed communications may be printed from the myAsuris.com account where they are posted, or a paper copy of any particular communication may be requested at any time using myAsuris.com or by contacting Asuris Customer Service at the number provided on my ID card.
- I may change the e-mail address for receipt of notice of electronic distributions or withdraw consent (returning to paper distribution) at any time and without charge using myAsuris.com or by contacting Asuris Customer Service as described in the previous bullet.

The e-mail address for receipt of notice of electronic distributions is _____ (Email address)

☐ I do not want electronic distribution. Unless my consent is not required for an electronic distribution, I elect to receive communications related to this coverage in a paper format.

Applicant's Signature ▶ _____ Date _____ (mm/dd/yyyy)

SECTION 9 - APPLICANT SIGNATURE

I hereby apply for enrollment, change, or cancellation of coverage as indicated above. I understand any coverage will be under the master contract between Asuris and my employer and I agree to the terms and conditions of the certificate issued pursuant to it. I agree to abide by the Employer's enrollment provisions and certify that all those who I seek to enroll, including myself, meet the eligibility criteria as agreed to by the Group in the master contract. I understand that coverage cannot start until after I have served an eligibility waiting period agreed to by the employer as recorded on Asuris's records.

An eligible individual not listed on this application will be considered as waiving coverage. I acknowledge that I have had the opportunity to enroll, but do not wish to make application for any eligible individual not listed. In waiving coverage, I am aware that waiving individuals (including me, if I am waiving) may enroll later only at my group's anniversary, unless qualified for a Special Enrollment Period.

SECTION 9 - APPLICANT SIGNATURE (continued)

If I have waived enrollment for myself or any of my dependents (including my eligible spouse or domestic partner) because of other health insurance or group health plan coverage, I may in the future be able to enroll the waived individuals in this plan, provided I request enrollment within 30 days after the other coverage of the individual(s) ends due to loss of eligibility or an employer's ceasing to contribute toward that other coverage. In addition, if I have a new dependent as a result of marriage or domestic partnership, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependents, provided that I request enrollment within 30 days after the marriage or domestic partnership, or within 60 days after the birth, adoption, or placement if payment of additional premium is required to provide coverage for the dependent child. To obtain more information about these rules, please call 1 (866) 228-7139.

Except by express amendment signed by an officer of Asuris, no person, including, but not limited to any independent producer, agent, or employee of Asuris or of my employer, may change the terms of the master contract, any of its amendments, or this application and no person may waive the requirement that I answer all questions on this application completely and accurately. I understand that this application will become part of the contract between Asuris and my employer.

I authorize my employer to act as my agent in all matters of administration of the group coverage, and acknowledge that my employer is in no way acting as agent for Asuris. I agree to pay the appropriate premium rates for myself and my enrolling dependents in advance, and authorize payroll deduction of premiums as required.

I authorize any source to release to Asuris, any medical, health, employment, and/or insurance information requested for any enrolled member. I acknowledge and understand that Asuris may request or disclose health information about me or my dependents (persons who are eligible for benefits coverage and are listed on the enrollment form) from time to time for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits, or as required by law. Health information requested or disclosed may be related to treatment or services performed by:

- A physician, dentist, pharmacist or other physical or behavioral health care practitioner;
- A clinic, hospital, long term care or other medical facility;
- Any other institution providing care, treatment, consultation, pharmaceuticals or supplies or;
- An insurance carrier or group health plan.

Health information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes). This acknowledgment does not apply to obtaining information regarding psychotherapy notes. A separate authorization will be used for psychotherapy notes.

I have provided these answers as part of the application procedure required by Asuris to enroll in coverage and I certify that all information completed on this form is true, correct, and complete. I understand that Asuris will rely on each answer in making coverage and rating determinations. It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

I hereby verify that I have reviewed all the information provided on this application (regardless of whether I completed it or someone else assisted me with completion) and certify that it is accurate and complete. I agree to promptly inform Asuris in writing if anything happens before my coverage takes effect that makes any answer on this application inaccurate or incomplete.

Applicant's Signature ▶ _____ Date (mm/dd/yyyy) _____