

AFFINITY HEALTH SYSTEM  
1570 Midway Place  
P.O. Box 120  
Menasha, WI 54952

Name of Employer \_\_\_\_\_  
Group # \_\_\_\_\_ Effective Date/Date of Change \_\_\_\_\_

<b>Type of Coverage</b>  <input type="checkbox"/> HMO  <input type="checkbox"/> POS	<b>CHECK REASON FOR APPLICATION</b> <input type="checkbox"/> Address Change <input type="checkbox"/> Special Enrollment <input type="checkbox"/> Waiver of Insurance Election	<input type="checkbox"/> New Subscriber <input type="checkbox"/> Group Transfer <input type="checkbox"/> PCP Change <input type="checkbox"/> COBRA Date _____	<input type="checkbox"/> Change Name <input type="checkbox"/> Cancel <input type="checkbox"/> Add a Family Member <input type="checkbox"/> Open Enrollment Date _____	Cancellation Reason _____ Add a Family Member Reason _____ Terminate a Family Member Reason _____ Other Reason _____
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**SUBSCRIBER INFORMATION (EMPLOYEE INFORMATION)**

Last	Legal First Name	Nickname	Middle Initial	<b>STATUS (Check)</b> <input type="checkbox"/> Single <input type="checkbox"/> Married Date of Full-Time Employment _____
Home Address (Include mailing address if different)				
City	State	Zip	County	<input type="checkbox"/> Hourly <input type="checkbox"/> Union <input type="checkbox"/> Salary <input type="checkbox"/> Non-Union
Home Telephone ( )		Work Telephone ( )		

Please use the Provider Directory to choose a Primary Care Physician for yourself and each of your covered dependent(s).

**SUBSCRIBER AND DEPENDENT(S) INFORMATION**

NAME (First, MI, Last) (Social Security Number required for processing.)	Date of Birth Mo./Day/Yr.	Relation to Subscriber	Sex M/F	If dependent is over 19, check		Required for processing HMO or POS Primary Care Physician (First & Last Name)	PCP ID #	Current Patient	
				Full-time Student	Disabled			Yes	No
01 EMPLOYEE NAME	/ /				<input type="checkbox"/>				
Social Security #									
02 SPOUSE NAME	/ /				<input type="checkbox"/>				
Social Security #									
03 DEPENDENT NAME	/ /	<input type="checkbox"/> Child <input type="checkbox"/> Grandchild <input type="checkbox"/> Stepchild <input type="checkbox"/> Guardianship		<input type="checkbox"/>	<input type="checkbox"/>				
Social Security #									
04 DEPENDENT NAME	/ /	<input type="checkbox"/> Child <input type="checkbox"/> Grandchild <input type="checkbox"/> Stepchild <input type="checkbox"/> Guardianship		<input type="checkbox"/>	<input type="checkbox"/>				
Social Security #									
05 DEPENDENT NAME	/ /	<input type="checkbox"/> Child <input type="checkbox"/> Grandchild <input type="checkbox"/> Stepchild <input type="checkbox"/> Guardianship		<input type="checkbox"/>	<input type="checkbox"/>				
Social Security #									

Network Health Plan requires all legal paperwork for insuring dependents involving guardianship and adoption.

**OTHER INSURANCE COVERAGE INFORMATION**

Do you or your family have health coverage through another group or employer?  Yes  No Will insurance continue after NHP begins?  Yes  No

Names of Individuals who have other coverage \_\_\_\_\_ Name of Insurance Company \_\_\_\_\_

Policy Holder \_\_\_\_\_ Policy # \_\_\_\_\_

Is spouse employed?  Yes  No Is there a divorce decree 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? \_\_\_\_\_ Responsible party's date of birth? \_\_\_\_\_

**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's medical and claims management personnel, when reasonably related to my application for coverage through Network Health Plan ("NHP"). 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 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 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 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 may cause significant delays in the processing of my claims. I also understand that NHP retains the right to release claim information received from health care providers to NHP 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 cancellation due to termination but must be signed by employer.

**EMPLOYEE SIGNATURE NOT REQUIRED IN CANCELLATION DUE TO TERMINATION BUT MUST BE SIGNED BY EMPLOYER.**

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_ Employer Signature \_\_\_\_\_ Date \_\_\_\_\_

**NETWORK HEALTH PLAN COMPLETE 1-7**

1. CODED BY	2. UDRWRG.	3. APPROVED BY	4. DATE APPROVED	5. EFFECTIVE DATE	6. ENTERED BY	7. DATE
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