SecurityHealth Plan℠

Promises kept, plain and simple.®

1515 North Saint Joseph Avenue
PO Box 8000
Marshfield, WI 54449-8000

1.800.472.2363 | 715.221.9555
TTY: 711
Fax: 715.221.9500

FOR STAFF/AGENT/BROKER USE ONLY	
Name of staff member/agent/broker (last, first)	
Agent number	National Producer Number (NPN)

Individual and Family

2018 Health Insurance Application

This form is designed for initial application for coverage. Please contact Security Health Plan with questions regarding this form.

Instructions: Complete the entire application for each person who is applying for coverage. **If a person is currently enrolled in Medicare, this application should not be completed for that enrolled individual.** If additional pages are needed to fully complete this application, please attach, sign and date each page.

Are you currently a Security Health Plan member: ☐ Yes ☐ No If yes, list your subscriber ID # _____

Security Health Plan coverage

Security Health Plan Select (EPO):
☐ Select $1,500 (20%) ☐ Select $2,000 (20%) ☐ Select $3,000 (25%)
☐ Select $2,500 (30%) ☐ Select $4,500 (30%) ☐ Select $5,000 (10%) ☐ Select $5,750 (30%)
☐ Select $6,000 (30%) ☐ Select $6,500 ☐ Select Protection ☐ Select $7,350
☐ Select $3,750 (HDHP) ☐ Select $5,500 (HDHP) ☐ Select $6,000 (HDHP)

Security Health Plan Protect (EPO): ☐ Protect $4,800 (HDHP) ☐ Protect $5,200 (25%)

Requested effective date (month/day/year)**:**
__ __ / __ __ / __ __ __ __
Your effective date will be the first of the month following administrative approval

Indicate the reason for submitting this application:
☐ Open enrollment
☐ Special enrollment (may require documentation; qualifying event and date required)
☐ Birth/Adoption ☐ Marriage ☐ Permanent move ☐ Loss of coverage
☐ Other _____ Event date __ __ / __ __ / __ __ __ __

Section A – Family representative

We'll need one adult in the family to be the contact person for your application.

First name, middle name, last name and suffix

Home address (leave blank if you don't have one) | Apartment or suite number

City | State | ZIP code | County

Mailing address (if different from home address) | Apartment or suite number

City | State | ZIP code | County

Phone number: (__ __ __) __ __ __ – __ __ __ __

Other phone number: (__ __ __) __ __ __ – __ __ __ __

Do you want to receive information by email: ☐ Yes ☐ No

If yes, email address _____

Do you need health coverage: ☐ Yes, answer all the questions below ☐ No, skip to Section B (leave the rest of this page blank)

Social Security number __ __ __ – __ __ – __ __ __ __

We need Social Security numbers (SSNs) for anyone who wants coverage. We use SSNs to verify citizenship. If someone doesn't have an SSN, visit socialsecurity.gov or call 1-800-772-1213. TTY users should call 1-800-325-0778.

Gender: ☐ Male ☐ Female | Date of birth (m/d/y) __ __ / __ __ / __ __ __ __ | Preferred spoken or written language (if not English)

Need help with your application? Visit www.securityhealth.org or call us at **1.855.862.6859**. Para obtener una copla de este formulario en Español, liame **1.855.862.6859**. If you need help in a language other than English, call **1.800.472.2363** and tell the customer service representative the language you need. We'll get you help at no cost to you. *TTY users should call 711.*

Are you a U.S. citizen or U.S. national: ☐ Yes ☐ No

If no, do you have eligible immigration status: ☐ Yes, fill in your document type and ID number below ☐ No

Immigration document type _____ Document ID number _____

Primary care provider name (first and last)

Facility/Clinic location where primary care is received

Section B – Tell us about anyone who needs health coverage

If you have more people to include, make a copy of this page and attach.

Person 2

First name, middle name, last name and suffix | Relationship to you

Social Security number ___ ___ ___ – ___ ___ – ___ ___ ___ ___

Gender: ☐ Male ☐ Female

Date of birth (month/day/year) ___ ___ / ___ ___ / ___ ___ ___ ___

Does **Person 2** live at the same address as you: ☐ Yes ☐ No

If no, list address _____

Name of the legal guardian or parent responsible for carrying health insurance for a minor child

Is **Person 2** a U.S. citizen or U.S. national: ☐ Yes ☐ No

If no, do they have eligible immigration status: ☐ Yes, fill in **Person 2's** document type and ID number below ☐ No

Immigration document type _____ Document ID number _____

Primary care provider name (first and last)

Facility/Clinic location where primary care is received

Person 3

First name, middle name, last name and suffix | Relationship to you

Social Security number ___ ___ ___ – ___ ___ – ___ ___ ___ ___

Gender: ☐ Male ☐ Female

Date of birth (month/day/year) ___ ___ / ___ ___ / ___ ___ ___ ___

Does **Person 3** live at the same address as you: ☐ Yes ☐ No

If no, list address _____

Name of the legal guardian or parent responsible for carrying health insurance for a minor child

Is **Person 3** a U.S. citizen or U.S. national: ☐ Yes ☐ No

If no, do they have eligible immigration status: ☐ Yes, fill in **Person 3's** document type and ID number below ☐ No

Immigration document type _____ Document ID number _____

Primary care provider name (first and last)

Facility/Clinic location where primary care is received

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Person 4

First name, middle name, last name and suffix | Relationship to you

Social Security number
___ ___ ___ – ___ ___ – ___ ___ ___ ___

Gender:
☐ Male ☐ Female

Date of birth (month/day/year)
___ ___ / ___ ___ / ___ ___ ___ ___

Does **Person 4** live at the same address as you: ☐ Yes ☐ No

If no, list address _____

Name of the legal guardian or parent responsible for carrying health insurance for a minor child

Is **Person 4** a U.S. citizen or U.S. national: ☐ Yes ☐ No

If no, do they have eligible immigration status: ☐ Yes, fill in **Person 4's** document type and ID number below ☐ No

Immigration document type _____ Document ID number _____

Primary care provider name (first and last)

Facility/Clinic location where primary care is received

Section C – Automatic premium payment authorization

Complete authorization if choosing automatic payment option.

Your first month's premium must be paid by check. After that, how would you like to make your monthly payment:

☐ Checking/Savings ACH withdrawal ☐ By mail ☐ Debit/Credit (call Customer Service at 1.800.472.2363)

Subscriber name (last, first, middle initial)

Subscriber address

Phone number

Deduct my monthly premium from:
☐ Checking (enclose voided check)
☐ Savings (account no. _____)

Financial institution of payor
(see sample below when completing 1 – 5 below)

1 Name

2 Branch

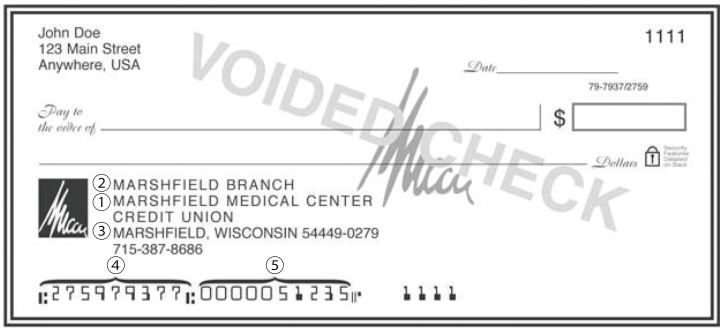
3 Address

4 ANA routing number

5 Account number

I (Payor) authorize Security Health Plan of Wisconsin, Inc., and the financial institution named above to initiate entries to my checking/savings account for payment of premiums. This authority will remain in effect until I notify you (Plan) and the financial institution in writing to cancel it in such time as to afford the financial institution a reasonable opportunity to act on it. I understand that the premium will be deducted on or after the 20th of the month. I can stop payment of any entry by notifying you and my financial institution 7 days before my account is charged. I understand the amount of an erroneous charge will be credited to my account upon notification.

_____ ____ /____ /____
Payor signature Date (m/d/y)



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Section D – Tobacco use

Is any applicant a tobacco user: ☐ Yes ☐ No

If yes, name of applicant(s) _____

Tobacco use is defined as use of tobacco on average of four or more times per week in the past 6 months.

Section E – American Indian or Alaska Native (AI/AN) family member(s)

Are you or is anyone in your family American Indian or Alaska Native:

☐ Yes, complete Section E (if you have more people to include, make a copy of this page and attach) ☐ No, skip to Section F

AI/AN Person 1	**AI/AN Person 2**	**AI/AN Person 3**
Name: First Middle	Name: First Middle	Name: First Middle
Last	Last	Last
Member of a federally recognized tribe: ☐ Yes, tribe name _____ ☐ No	Member of a federally recognized tribe: ☐ Yes, tribe name _____ ☐ No	Member of a federally recognized tribe: ☐ Yes, tribe name _____ ☐ No

To help us meet the needs of our members more effectively, complete the following information regarding your spoken language, written language, race and ethnicity. Your answers will not affect your enrollment.

		Subscriber	Spouse	Dependent Name _____	Dependent Name _____	Dependent Name _____
Language	What is your preferred spoken language?	☐ English ☐ Specify _____	☐ English ☐ Specify _____	☐ English ☐ Specify_____	☐ English ☐ Specify_____	☐ English ☐ Specify_____
	What is your preferred written language?	☐ English ☐ Specify _____	☐ English ☐ Specify _____	☐ English ☐ Specify_____	☐ English ☐ Specify_____	☐ English ☐ Specify_____
Race/Ethnicity	What race are you?	☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Specify _____ ☐ Two or more races	☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Specify _____ ☐ Two or more races	☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Specify_____ ☐ Two or more races	☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Specify_____ ☐ Two or more races	☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Specify_____ ☐ Two or more races
	What is your ethnic background?	☐ Hispanic/Latino ☐ Not Hispanic/Latino	☐ Hispanic/Latino ☐ Not Hispanic/Latino	☐ Hispanic/Latino ☐ Not Hispanic/Latino	☐ Hispanic/Latino ☐ Not Hispanic/Latino	☐ Hispanic/Latino ☐ Not Hispanic/Latino

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Section F – Read and sign this application

- I'm signing this application under penalty of perjury, which means I've provided true answers to all of the questions to the best of my knowledge. I know that I may be subject to penalties under federal law if I intentionally provide false or untrue information.
- I know that I must tell Security Health Plan if anything changes from what I wrote on this application. I can visit www.securityhealth.org or call **1.855.862.6859** to report any changes. I understand that a change in my information could affect the eligibility for member(s) of my household.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting hhs.gov/ocr/office/file.
- I know that my information on this form will only be used to determine eligibility for health coverage and will be kept private as required by law.
- Note the name of anyone who is seeking health care coverage through this application who is incarcerated (detained or jailed) _____
- I understand that my information will be used to check eligibility for health coverage. If the information doesn't match, I may be asked to send proof to Security Health Plan.

The person who filled out Section A should sign this application. If you're an authorized representative, you may sign here.

Signature _____ Date (m/d/y) _____ /_____ /_____

Section G – Complete this section if someone assisted you in the completion of this application

The following person assisted me in completing the application _____

Explain the assister's relationship to you and your family _____

Assister's address _____ Assister's phone number _____

Section H – Mail completed application

Mail your signed application to: Security Health Plan, 1515 N. Saint Joseph Ave., PO Box 8000, Marshfield, WI 54449-8000

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