SecurityHealth Plan℠

Promises kept, plain and simple.®

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

1.844.293.9624 | 715.221.9258
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

2022 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

SimplyOne (EPO):

☐ SimplyOne $1,500 - 30% ☐ SimplyOne $3,500 - 30% ☐ SimplyOne $4,800 - 30% ☐ SimplyOne $6,950 - 30%
☐ SimplyOne $4,500 HDHP ☐ SimplyOne $6,200 HDHP ☐ SimplyOne $7,500 ☐ SimplyOne $8,700
☐ SimplyOne $8,700 Copay ☐ SimplyOne Protection (Catastrophic)

Select (EPO):

☐ Select $1,500 - 30% ☐ Select $3,500 - 30% ☐ Select $4,800 - 30% ☐ Select $6,950 - 30%
☐ Select $4,500 HDHP ☐ Select $6,200 HDHP ☐ Select $7,500 ☐ Select $8,700
☐ Select $8,700 Copay ☐ Select Protection (Catastrophic)

Enrich (HMO):

☐ Enrich $1,500 - 30% ☐ Enrich $3,500 - 30% ☐ Enrich $4,800 - 30% ☐ Enrich $6,950 - 30%
☐ Enrich $4,500 HDHP ☐ Enrich $6,200 HDHP ☐ Enrich $7,500 ☐ Enrich $8,700
☐ Enrich $8,700 Copay ☐ Enrich Protection (Catastrophic)

Requested effective date (mm/dd/yyyy):

___ ___ / ___ ___ / ___ ___ ___ ___

Your effective date will be the first of the month following administrative approval

Indicate the reason for submitting this application:

☐ Open enrollment
☐ Special enrollment (documentation, qualifying event and event 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			
Physical address (PO box not accepted)			Apartment or suite number
City	State	ZIP code	County
Mailing address (if different from physical address)			Apartment or suite number
City	State	ZIP code	County
Home number (___ ___ ___) ___ ___ ___ – ___ ___ ___ ___	Cell number (___ ___ ___) ___ ___ ___ – ___ ___ ___ ___		
Email address			

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 **1.844.293.9624** 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*.

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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 www.socialsecurity.gov or call 1-800-772-1213. TTY users should call 1-800-325-0778.

Gender: ☐ Male ☐ Female	Date of birth (mm/dd/yyyy) ___ ___ / ___ ___ / ___ ___ ___ ___	Preferred spoken or written language (if not English)

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 (mm/dd/yyyy) ___ ___ / ___ ___ / ___ ___ ___ ___

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 (mm/dd/yyyy) ___ ___ / ___ ___ / ___ ___ ___ ___

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 ______________

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Primary care provider name (first and last)

Facility/Clinic location where primary care is received

Person 4

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

Social Security number	Gender:	Date of birth (mm/dd/yyyy)
___ ___ ___ – ___ ___ – ___ ___ ___ ___	☐ Male ☐ Female	___ ___ / ___ ___ / ___ ___ ___ ___

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:

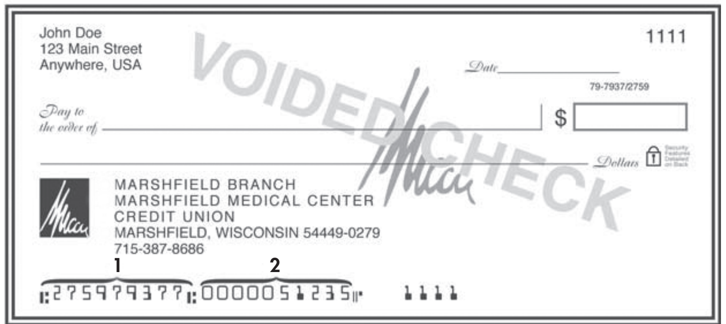
☐ Checking/Savings ACH withdrawal ☐ By mail ☐ Debit/Credit (call Customer Service at 1.844.293.9624)

Full name on bank account	Financial institution of payer *(see sample below when completing 1 – 2 below)*

Billing address

1 ANA routing number	2 Account number

I (Payer) 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.



___________________________ ___ /___ /___
Payer signature Date (mm/dd/yy)

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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 ________
Language	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 ________	☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Specify ________	☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Specify ________	☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Specify ________	☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Specify ________
Race/Ethnicity	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 (mm/dd/yy) __ __ /__ __ /__ __

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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, fax or email your signed application to:

Attn: Enrollment Services
Security Health Plan
1515 North Saint Joseph Ave
PO Box 8000
Marshfield WI 54449-8000

Fax: 715-221-9974

Email: shpmember@securityhealth.org

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Discrimination is against the law

Security Health Plan of Wisconsin, Inc., complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in the administration of the plan, including enrollment and benefit determinations. Security Health Plan does not exclude people or treat them differently because of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status.

Security 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 interpreters
  - Information written in other languages

If you need these services, contact Customer Service at 1-800-472-2363 (TTY 711). If you believe that Security Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status, you can file a grievance with:

Security Health Plan
Attn: Grievances
1515 North Saint Joseph Avenue
Marshfield, WI 54449-8000

Phone: 715-221-9596 (TTY: 711) Fax: 715-221-9424
Email: shp.appeals.grievance@securityhealth.org

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, Security Health Plan can 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

Phone: 1-800-368-1019 or 1-800-537-7697 (TDD)

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

Language assistance services

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-800-472-2363 (TTY 711)

Español (Spanish)
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-472-2363 (TTY 711)

Hmoob (Hmong)
LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-472-2363 (TTY 711)

繁體中文 (Chinese)
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-472-2363 (TTY 711) 。

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Language assistance services (continued)

Deutsch (German)
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-472-2363 (TTY 711)

العربية (Arabic)
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-472-2363 (رقم هاتف الصم والبكم 711).

Русский (Russian)
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-472-2363 (телетайп 711).

한국어 (Korean)
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-472-2363 (TTY 711) 번으로 전화해 주십시오.

Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-472-2363 (TTY 711).

Deitsch (Pennsylvania Dutch)
Wann du Deitsch schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: 1-800-472-2363 (TTY 711).

ພາສາລາວ (Lao)
ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-472-2363 (TTY 711).

Français (French)
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-472-2363 (ATS 711).

Polski (Polish)
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-472-2363 (TTY 711).

हिंदी (Hindi)
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-472-2363 (TTY 711) पर कॉल करें।

Shqip (Albanian)
KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-472-2363 (TTY 711).

Tagalog (Filipino)
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-472-2363 (TTY 711).

Oroomiffa (Oromo/Somalia)
XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-472-2363 (TTY 711).

Large print – If you require materials in large print, please call 1-800-472-2363 (TTY 711).

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