SecurityHealth Plan℠

Promises kept, plain and simple.®

1515 North Saint Joseph Avenue
P.O. 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

2026 Health Insurance Application

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

Instructions: Complete the entire application for each person who is applying for coverage. If additional pages are needed to fully complete this application, attach, sign and date each page.

If a person is currently enrolled in Medicare, this application should not be completed for that enrolled individual.

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

Security Health Plan coverage

SimplyOne (EPO):
- ☐ SimplyOne $2,000 - 25%
- ☐ SimplyOne $3,500 - 30%
- ☐ SimplyOne $6,000 - 40%
- ☐ SimplyOne $4,000 - 50%
- ☐ SimplyOne $5,000 HDHP
- ☐ SimplyOne $7,500 HDHP
- ☐ SimplyOne $7,500
- ☐ SimplyOne $9,500
- ☐ SimplyOne Protection (Catastrophic)

Select (EPO):
- ☐ Select $2,000 - 25%
- ☐ Select $3,500 - 30%
- ☐ Select $6,000 - 40%
- ☐ Select $4,000 - 50%
- ☐ Select $5,000 HDHP
- ☐ Select $7,500 HDHP
- ☐ Select $7,500
- ☐ Select $9,500
- ☐ Select Protection (Catastrophic)

Enrich (HMO):
- ☐ Enrich $2,000 - 25%
- ☐ Enrich $3,500 - 30%
- ☐ Enrich $6,000 - 40%
- ☐ Enrich $4,000 - 50%
- ☐ Enrich $5,000 HDHP
- ☐ Enrich $7,500 HDHP
- ☐ Enrich $7,500
- ☐ Enrich $9,500
- ☐ Enrich Protection (Catastrophic)

Premier (HMO):
- ☐ Premier $2,000 - 25%
- ☐ Premier $3,500 - 30%
- ☐ Premier $6,000 - 40%
- ☐ Premier $4,000 - 50%
- ☐ Premier $5,000 HDHP
- ☐ Premier $7,500 HDHP
- ☐ Premier $7,500

Requested effective date (m/d/y):

_____ / _____ / _____

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 (m/d/y) _____ / _____ / _____

Select if any part of premium is being paid through a qualified employer HRA.

☐ Individual Coverage HRA (ICHRA) ☐ Qualified Small Employer HRA (QSEHRA)

Section A – Family representative

List one adult in the family to be the contact person for your application.

First name, middle name, last name and suffix

Physical address (P.O. 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 phone (___ ___ ___) ___ ___ ___ – ___ ___ ___ ___

Cell phone (___ ___ ___) ___ ___ ___ – ___ ___ ___ ___

Email

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 will 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

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

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

Sex assigned at birth	Date of birth (m/d/y)	Preferred language (if not English)
☐ Male ☐ Female	_____ / _____ / _____	

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	Sex assigned at birth	Date of birth (m/d/y)
___ ___ ___ – ___ ___ – ___ ___ ___ ___	☐ Male ☐ Female	_____ / _____ / _____

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	Sex assigned at birth	Date of birth (m/d/y)
___ ___ ___ – ___ ___ – ___ ___ ___ ___	☐ Male ☐ Female	_____ / _____ / _____

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
___ ___ ___ – ___ ___ – ___ ___ ___ ___

Sex assigned at birth
☐ Male ☐ Female

Date of birth (m/d/y)
_____ / _____ / _____

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 – Select a premium payment method – Choose Option A or B below.

You may make one-time payments or set up recurring payments. Note: ID cards are not sent until payment is received.

☐ **Option A: Pay online or via check**
You will receive a premium statement. You may choose to pay online via *My Security Health Plan* at member.securityhealth.org/Account/Login or by mailing a check.

☐ **Option B: Pay automatically**
Automatic premium payment plans must be set up before the 10th of the month to process on the 20th of the month. If the recurring plan is set up after the 10th, a one-time payment can be made online via *My Security Health Plan* or by check. If a one-time payment is not made, two months of premium will be pulled from your account the following month.

Select how you plan to make your payment:

☐ Automatic recurring payment via checking/savings

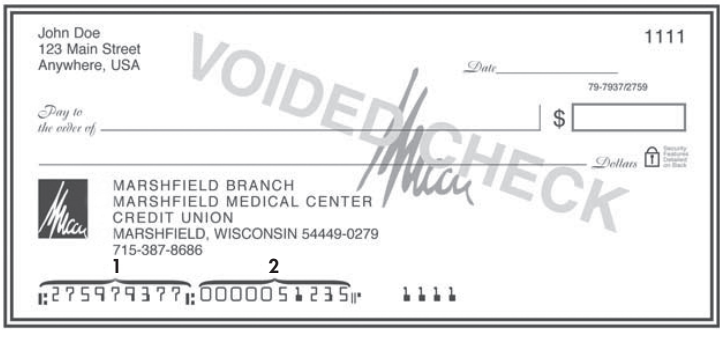
☐ Automatic recurring payment via debit/credit card (skip to Section D)

Full name on bank account | Financial institution of payer

Billing address

1 ANA routing number (see sample below) | **2** Account number (see sample below)

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 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 (m/d/y)

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Section D – Credit/debit card payment method

We accept Visa, MasterCard and Discover.

Name on card		
Card number		
Card security code (3-digit code on back of card) ____ ____ ____	Expiration date (mm/yy)	
Billing address		
City	State	ZIP code

I hereby authorize Security Health Plan of Wisconsin, Inc., and Chase Paymentech Services to initiate a debit to my credit or debit card for payment of premiums. I understand that this authorization is to remain in effect unless I notify Security Health Plan and the financial institution of a change within a time and manner as to afford Security Health Plan and the financial institution a reasonable opportunity to act on it.

_____ _____/_____/_____

Payor signature Date (m/d/y)

Section E – 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 four or more times per week in the past six months.

Section F – Native American or Alaska Native (NA/AN) family member(s)

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

☐ Yes, complete Section F (if you have more people to include, make a copy of this page and attach)

☐ No, skip to Section G

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

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Section G – Language, race, ethnicity

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

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

☐ Choose not to disclose

		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 ☐ Hispanic/Latino ☐ Native American ☐ Alaska Native ☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Specify _____	☐ White ☐ Black or African American ☐ Hispanic/Latino ☐ Native American ☐ Alaska Native ☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Specify _____	☐ White ☐ Black or African American ☐ Hispanic/Latino ☐ Native American ☐ Alaska Native ☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Specify _____	☐ White ☐ Black or African American ☐ Hispanic/Latino ☐ Native American ☐ Alaska Native ☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Specify _____	☐ White ☐ Black or African American ☐ Hispanic/Latino ☐ Native American ☐ Alaska Native ☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Specify _____

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Section H – Read and sign this application

- I am signing this application under penalty of perjury, which means I have 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 myself and/or member(s) of my household.
- I know that under federal law, discrimination is not permitted on the basis of race, color, national origin, religion, pregnancy and related conditions, sex (including sexual orientation, gender identity, sex stereotypes, sex characteristics and intersex traits), age, disability, health status, marital status, arrest or conviction record or military participation. I can file a complaint of discrimination by visiting hhs.gov/ocr/office/file.
- Unless otherwise stated, I understand and agree that information obtained by using this application will be used by Security Health Plan to determine eligibility for benefits. I agree to cooperate in providing Security Health Plan with any additional information necessary to process this application.
- Note the name of anyone who is seeking health care coverage through this application who is incarcerated (detained or jailed) _____
- I understand the insurance broker assisting me with my plan purchase receives a monthly commission of $17 – $20 from Security Health Plan of WI, Inc.

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

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

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

The following person assisted me in completing the application _____

Explain their relationship to you and your family _____

Their address _____ Their phone number _____

Section J – Mail completed application

Mail, fax or email your signed application to:

Attn: Enrollment Services
Security Health Plan
1515 North Saint Joseph Avenue
P.O. 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, exclude or treat people differently on the basis of race, color, national origin, religion, pregnancy and related conditions, sex (including sexual orientation, gender identity, sex stereotypes, sex characteristics and intersex traits), age, disability, health status, marital status, arrest or conviction record or military participation in the administration of the plan, including enrollment and benefit determinations.

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, religion, pregnancy and related conditions, sex (including sexual orientation, gender identity, sex stereotypes, sex characteristics and intersex traits), age, disability, health status, marital status, arrest or conviction record or military participation in the administration of the plan, including enrollment and benefit determinations, you can file a grievance with a Compliance & Privacy Specialist at:

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, a Security Health Plan Compliance & Privacy Specialist 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 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 (TDD 800–537–7697)

More information is available at http://www.hhs.gov/ocr/index.html.

Limited English Proficiency Language Services

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-844-293-9624 (TTY 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-293-9624 (TTY 711).

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-844-293-9624 (TTY 711).

If you require materials in large print, please call 1-844-293-9624 (TTY 711).

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