

Employee Policy Change Request Form



Mail to: Aspirus Health Plan, Inc., P.O. Box 1062, Minneapolis, MN 55440 • Email: Enrollment@aspirushealthplan.com

Instructions: Check and complete the changes that apply and sign where indicated.

Section 1 - Employee Information Changes						
Employee Last Name		Employee First Name			MI	ID Number
<input type="checkbox"/> Name Change	Change From		Change To		Reason For Change	
	If Married, Spouse's Name		Date of Marriage		Date of Divorce (if applicable)	
<input type="checkbox"/> Phone Number Change	<input type="radio"/> Home <input type="radio"/> Work <input type="radio"/> Cell		Change To			
<input type="checkbox"/> Email Address Change	Change To					
<input type="checkbox"/> Address Change	Change applies to		Street		Apartment Number	
	<input type="radio"/> Residence Address <input type="radio"/> Mailing Address		City		State	ZIP Code
<input type="checkbox"/> Plan Change	Change To					
<input type="checkbox"/> Other Change	Please Indicate					
Section 2 - Adding or Deleting Coverage for Spouse and Dependents						
<input type="checkbox"/> Addition of Spouse or Dependents						
Last Name	First Name	MI	Gender <input type="radio"/> M <input type="radio"/> F	Date of Birth	Relationship to Member	Social Security #
Last Name	First Name	MI	Gender <input type="radio"/> M <input type="radio"/> F	Date of Birth	Relationship to Member	Social Security #
Last Name	First Name	MI	Gender <input type="radio"/> M <input type="radio"/> F	Date of Birth	Relationship to Member	Social Security #
<input type="checkbox"/> Deletion of Spouse or Dependents						
Last Name	First Name	MI	Date of Birth	Termination Date		
Last Name	First Name	MI	Date of Birth	Termination Date		
Last Name	First Name	MI	Date of Birth	Termination Date		
Section 3 - Notice of Special Enrollment Rights for Health Coverage						

If you are declining enrollment for yourself or your dependents (including your spouse/domestic partner) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose coverage (or if the employer stopped contributing toward you or your dependent's other coverage).

Loss of coverage events include, but are not limited to: (a) the person no longer lives, resides, or works within his or her HMO service area, the HMO does not provide coverage for that reason and there is no other coverage under the plan for the individual; (b) a dependent loses dependent status because he or she attains a particular age; (c) the plan no longer offers any benefits to a class of similarly situated individuals (such as if the plan terminates coverage for all part-time workers); and (d) a benefit package option terminates or the issuer stops operating in the group market.

However, you must request enrollment within 31 days (or 60 days for Medicaid eligibility, birth or adoption of a child) after you or your dependent's other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, domestic partnership registry, birth, adoption or placement for adoption, you may be able to enroll yourself and other dependents. However, you must request enrollment within 31 days after the marriage, domestic partnership registry, birth, adoption or placement for adoption.

This notice is for informational purposes only and is informing you of your special enrollment rights.

Section 4 - Terms and Conditions

I hereby enroll for coverage under the insurance coverage(s) for which I am presently eligible, or for which I may become eligible. I understand and agree that the information obtained by using this Application will be used by Insurer or TPA to determine eligibility for benefits. I, on behalf of myself, my spouse/domestic partner and my dependent child(ren), if any, named herein, agree to cooperate in providing Insurer or TPA with information needed to process this Application.

If any payroll deductions are required for this coverage, I authorize such deductions from my earnings. I reserve the right to revoke this deduction authorization at any time upon written notice to the employer.

An Application should not be submitted more than 45 days prior to the effective date. This document will become a part of the insurance contract when coverage is approved and issued.

I acknowledge that I have read and completed the entire Application. If I received assistance in reading or completing this Application, I have identified in the space provided below the person(s) who provided me with such assistance. I additionally agree that Insurer or TPA is not liable for any statement, representation, or other information provided to me, my spouse/domestic partner or my dependent child(ren) that is not expressly contained in a written document provided by Insurer or TPA and signed by an authorized officer of the insurer or TPA. I agree that no insurance will be effective until the date specified by the company on the policy after this application has been accepted. I also understand that if I decline any coverage, future changes in coverage are NOT automatic and may be subject to Insurer or TPA's approval.

Signature of Person Providing Assistance (if applicable)	Print Name
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I acknowledge that:

- This application becomes part of my Medical Coverage Agreement.
- The signatures shown below allow me, my spouse/domestic partner to release to Insurer or TPA information about any person listed on my Individual and Family plan application documents.
- Under the Health Insurance Portability and Accountability Act (HIPAA), Insurer or TPA, without my authorization, may only release limited information about my selection of a plan to my spouse/domestic partner, adult/minor children, producer, or anyone else.
- Insurer or TPA may collect, use, or disclose the nonpublic personal information of persons listed on this application as required or permitted by law and to conduct routine business functions such as determining eligibility for enrollment, reviewing prior coverage for waiting periods, paying claims, and, if appropriate, coordinating benefits, and fulfilling other legal obligations specified in my Medical Coverage Agreement.
- I have read and agree to the Terms and Conditions included in this application. I declare that, to the best of my knowledge, all information I have provided with this application is true and complete, and that all of the persons for whom I am requesting enrollment are eligible for coverage. I understand that if I have made intentionally false or misleading statements on behalf of myself or any family members, the Medical Coverage Agreement may be canceled retroactively to its effective date. I further understand that it is a crime to knowingly provide false, incomplete, or misleading information for the purpose of fraudulently obtaining health coverage. Penalties may include imprisonment, fines, and denial of benefits.

For more information on Special Enrollment Period requirements, please visit our website: aspirushealthplan.com

Documentation: I am enclosing all documentation as required, including, if applicable, documentation to enroll due to a special qualifying event. Any missing information may delay processing of my application.

Signature: This application has been signed by me and my spouse, if applicable.

If not the primary applicant, I am the:

Parent Holder of Power of Attorney (*attach legal documentation*) Legal Guardian (*attach legal documentation*)

Primary Applicant/Parent/Legal Guardian Signature	Date
Spouse Signature (<i>if applicable</i>)	Date

Nondiscrimination & Language Access Policy

Aspirus Health Plan, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. We do not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

We will:

Provide 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)

Provide 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 us at the phone number shown on the inside cover of this contract, your id card, or aspirushealthplan.com.

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a grievance with:

Nondiscrimination Grievance Coordinator
Aspirus Health Plan, Inc.
PO Box 1062
Minneapolis, MN 55440
Phone: 1.866.631.5404 (TTY: 711)
Fax: 763.847.4010
Email: customerservice@aspirushealthplan.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Nondiscrimination Grievance Coordinator 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, D.C. 20201
1.800.368.1019, 800.537.7697 (TDD)

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

Language Assistance Services

Albanian: KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1.866.631.5404 (TTY: 711).

Arabic: تنبيه: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك مجاناً. اتصل بن أعلى رقم الهاتف 1.866.631.5404 (رقم هاتف الصم والبك : 711)

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelezle 1.866.631.5404 (ATS : 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1.866.631.5404 (TTY: 711).

Hindi: _यान द_ : य_द आप िहंदी बोलते ह_ तो आपके िलए मु_त म_ भाषा सहायता सेवाएं उपल_ध ह_। 1.866.631.5404 (TTY: 711) पर कॉल कर_।

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1.866.631.5404 (TTY: 711).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1.866.631.5404 (TTY: 711)번으로 전화해 주십시오.

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1.866.631.5404 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1.866.631.5404 (телетайп: 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.866.631.5404 (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nangwalang bayad. Tumawag sa 1.866.631.5404 (TTY: 711)

Traditional 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 1.866.631.5404 (TTY:711)。

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1.866.631.5404 (TTY: 711).

Pennsylvania Dutch: Wann du Deitsch (Pennsylvania German / Dutch) schwetzsch, kannscht du mitaus Koschte ebbergricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1.866.631.5404 (TTY: 711).

Lao: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1.866.631.5404 (TTY:711).