Enrollment Application
For Small Employer Group Employees

Important Notices Regarding Your Enrollment Application

To properly administer your health benefit plan, a certain amount of information is required.

Please note the following:

- With respect to medical coverage, if you or any of your eligible dependents do not enroll in Avera Health Plans when it is first made available and want to enroll later, you will need to wait until the next open enrollment period unless a special enrollment exception applies.
- If the subscriber is required by court or administrative order to provide health care coverage to a dependent, a copy of the court or administrative order must be submitted to Avera Health Plans.
- Any incomplete or missing information will delay the processing of the enrollment request.
- The fully completed application must be received by Avera Health Plans in order for this application to be considered valid.
- If you commit fraud or intentionally misrepresent your answers on this application, Avera Health Plans has the right to rescind your policy.
- Avera Health Plans reserves the right to change premium rates upon renewal.
- Your signature on the attached enrollment form verifies that you have read and understand the enclosed statements and acknowledge that all information provided on the enrollment form is complete and true.

Avera Health Plans

5300 S. Broadband Ln.
Sioux Falls, SD 57108-2221
Phone: 605-322-4545
Fax: 605-322-4689
Toll Free: 1-888-322-2115
ahpenrollment@avera.org

ENROLLMENT APPLICATION
For Small Employer Groups

MUST BE COMPLETED BY EMPLOYER

Employer Name: _____
Group Number: _____
Employer Location: _____
Requested Effective Date: _____
☐ New Hire: _____
☐ Special Enrollment: Reason: _____
☐ Open Enrollment: _____
☐ Add Newly Acquired Dependent(s): _____
☐ COBRA: Reason: _____
☐ Date COBRA started: _____

SUBSCRIBER INFORMATION

Social Security Number (not used on ID cards) _____ Subscriber Last Name _____ First Name _____ Middle Initial _____

Street or Mailing Address _____ City _____ State _____ ZIP _____ County _____

Home Phone _____ Work Phone _____ Email Address _____ Primary Care Physician _____

Date of Birth _____ Gender: ☐ Male or ☐ Female Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced

Date of Hire _____ ☐ Hourly or ☐ Salary

Race:	Ethnicity:	Language:
White Black or African American American Indian and Alaska Native Asian Native Hawaiian and other Pacific Islander Other I choose not to answer	Hispanic/Latino Not Hispanic/Latino I choose not to answer	English Other Indo-European Language Asian and Pacific Island Languages Chinese Spanish I choose not to answer

PLAN SELECTION **Availability based on your employer's selection.**

Benefit Plan Selection (for multiple options) _____

FAMILY INFORMATION **Complete for covered dependents only.** **(If more space is needed, attach an additional sheet of paper, sign and date it.)**

	Legal Last Name, First Name, Middle Initial	Gender (Male or Female)	Relationship	Birth Date* (Mo/Day/Yr)	Social Security Number**
02	Spouse	M F	Spouse		

Race:	Ethnicity:	Language:
White Black or African American American Indian and Alaska Native Asian Native Hawaiian and other Pacific Islander Other I choose not to answer	Hispanic/Latino Not Hispanic/Latino I choose not to answer	English Other Indo-European Language Asian and Pacific Island Languages Chinese Spanish I choose not to answer

	Legal Last Name, First Name, Middle Initial	Gender (Male or Female)	Relationship	Birth Date* (Mo/Day/Yr)	Social Security Number**
03	Child	M F			

Race:	Ethnicity:	Language:
White Black or African American American Indian and Alaska Native Asian Native Hawaiian and other Pacific Islander Other I choose not to answer	Hispanic/Latino Not Hispanic/Latino I choose not to answer	English Other Indo-European Language Asian and Pacific Island Languages Chinese Spanish I choose not to answer

	Legal Last Name, First Name, Middle Initial	Gender (Male or Female)	Relationship	Birth Date* (Mo/Day/Yr)	Social Security Number**
04	Child	M F			

Race:	Ethnicity:	Language:
White Black or African American American Indian and Alaska Native Asian Native Hawaiian and other Pacific Islander Other I choose not to answer	Hispanic/Latino Not Hispanic/Latino I choose not to answer	English Other Indo-European Language Asian and Pacific Island Languages Chinese Spanish I choose not to answer

	Legal Last Name, First Name, Middle Initial	Gender (Male or Female)	Relationship	Birth Date* (Mo/Day/Yr)	Social Security Number**
05	Child	M F			

Race:	Ethnicity:	Language:
White	Hispanic/Latino	English
Black or African American	Not Hispanic/Latino	Other Indo-European Language
American Indian and Alaska Native	I choose not to answer	Asian and Pacific Island Languages
Asian		Chinese
Native Hawaiian and other Pacific Islander		Spanish
Other		I choose not to answer
I choose not to answer		

	Legal Last Name, First Name, Middle Initial	Gender (Male or Female)	Relationship	Birth Date* (Mo/Day/Yr)	Social Security Number**
06	Child	M F			

Race:	Ethnicity:	Language:
White	Hispanic/Latino	English
Black or African American	Not Hispanic/Latino	Other Indo-European Language
American Indian and Alaska Native	I choose not to answer	Asian and Pacific Island Languages
Asian		Chinese
Native Hawaiian and other Pacific Islander		Spanish
Other		I choose not to answer
I choose not to answer		

*Eligible dependents are defined only as married spouse and natural dependent children, stepchildren, adopted children or children under legal custody who are within the limiting age.
NOTE: If you have adult children are between the ages of 19 and 26 and have access to employer-sponsored health coverage, please notify your employer.

INSURANCE WAIVER SECTION

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll your dependent(s), provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

I have been informed that an employer sponsored health benefit plan is available through my employer to my dependents and me. On behalf of myself and my dependents, I am voluntarily electing not to enroll in the health benefit plan sponsored by my employer.

I am not applying for coverage because:

- ☐ I am covered by other employer group benefit plan (please list) _____
- ☐ My dependents are covered by other employer group benefit plan (please list) _____
- ☐ I am covered by an individual benefit plan (please list) _____
- ☐ Other reason (please explain) _____

AUTHORIZATION TO RELEASE INFORMATION TO AVERA HEALTH PLANS

By signing this application, I authorize any consumer reporting agency, medical information bureau, insurance company, or other person having information about me or my dependents to release to Avera Health Plans or any of its designees any and all records or information pertaining to medical history, health history questions, health statement or health services rendered to me or my dependents, including drug and/or alcohol abuse information, or any information regarding responsibility for payment to Avera Health Plans for any administrative purpose.

I also authorize Avera Health Plans, its employees and agents, to disclose records and information as permitted by law to authorized persons including other insurers or reinsurers, vendors of employee insurance or cafeteria plans. Avera Health Plans may be compensated by other insurers or vendors. A copy of this authorization is as valid as the original. Unless otherwise stated or revoked by my written revocation, this authorization terminates when enrollment in Avera Health Plans terminates. This information will be used to determine eligibility for benefits, payment responsibility and utilization review. I agree to abide by the documents describing my coverage, (including but not limited to the Certificate of Coverage, Member Handbook and Summary of Benefits and Coverage, the Evidence of Coverage and Summary Plan Document) and to pay any applicable premiums, co-payments, coinsurance and deductibles. I understand that my enrollment or eligibility for benefits in Avera Health Plans is conditional upon me signing this authorization and that failure to sign may result in being denied enrollment or benefits.

Subscriber's Signature:_____ Date: _____

Employer's Representative Signature (Required):_____ Date:_____

Please continue to the next page and complete the required information requested.

OTHER INSURANCE INFORMATION

Applicant Name: _____

1. Have you or any of your family members recently lost coverage from another health insurance policy?
   ☐ Yes ☐ No If yes, you must provide the following information in the box below:
2. Will you or any of your family members continue to be covered by another health policy after the effective date with Avera Health Plans?
   ☐ Yes ☐ No If yes, you must provide the following information to coordinate benefits:

Insurance Company	Insurance Company Phone Number	Covered Individual	Member/ ID Number	Type of Policy Group or Individual (If Group, List Employer)	Effective Date	Termination Date
	(____)____- _____			☐ Group, Employer Name: ☐ Individual		
	(____)____- _____			☐ Group, Employer Name: ☐ Individual		

OPTIONAL HEALTH STATEMENTS

We offer health and wellness programs as additional benefits for our members. Your responses to the questions below assist us in providing additional benefits to you.

1. Have you or any of your family members been diagnosed with any of the following conditions:
   ☐ Asthma ☐ Heart Disease ☐ Diabetes
   ☐ High Blood Pressure and/or High ☐ Pregnancy, Due Date: _____
2. Cholesterol Please provide additional details:

Name of Person	Name of Condition	Dates and Duration of Treatment	Type of Treatment	Indicate Degree of Recovery Partial – Half – ¾ – Full
				☐ 25% ☐ 50% ☐ 75% ☐ 100%
				☐ 25% ☐ 50% ☐ 75% ☐ 100%
				☐ 25% ☐ 50% ☐ 75% ☐ 100%

3. Would you like help in finding an in-network physician or a call regarding a specific medical condition?
   ☐ Yes ☐ No If yes, best time to call: _____ ☐ a.m. ☐ p.m. Phone Number (_____)_____— _____

LIFE INSURANCE BENEFICIARY SECTION

Primary Beneficiary

Name: _____
Address: _____
Relationship: _____

Contingent Beneficiary

Name: _____
Address: _____
Relationship: _____

ACKNOWLEDGEMENT AGREEMENT

Your initials below verify that you have read and understand the statements provided in the application and acknowledge that all the information you are providing Avera Health Plans is complete and true.

Initial:_____ Date: _____

Thank You.
Upon completion of the application, please submit to your employer or agent to process your enrollment with Avera Health Plans.

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Sioux Falls, SD 57108-2221
Phone: 605-322-4545
Fax: 605-322-4689
Toll Free: 1-888-322-2115
ahpenrollment@avera.org

Discrimination is Against the Law

Avera Health Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Avera Health Plans does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Avera Health Plans

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters and 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 and information written in other languages.

If you need these services, contact the Avera Health Plans Customer Care team at 1-888-322-2115, (TTY 711), 8 a.m. to 5 p.m. CST, Monday through Friday.

If you believe that Avera Health Plans has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

Complaint and Appeals Coordinator
Avera Health Plans
5300 S Broadband Ln
Sioux Falls, SD 57108-2221

Fax 1-800-269-8561
Email ComplaintAppeals@AveraHealthPlans.com

You can file a grievance in person or by mail, fax, or email. You may also contact the Complaint and Appeals Coordinator if you need assistance with filing a complaint.

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 call 1-800-368-1019 or 1-800-537-7697 (TDD). Or mail:
US Department of Health and Human Services,
200 Independence Avenue SW Room 509F, HHH Building,
Washington, D.C. 20201

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

Getting Help in Other Languages

Language assistance services are available free of charge. Our Customer Care team is available 8 a.m. to 5 p.m. CST, Monday – Friday, toll-free at 1-888-322-2115 (TTY: 1-800-877-1113).

- ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-322-2115 (TTY: 1-800-877-1113).
- LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-888-322-2115 (TTY: 1-800-877-1113).
- CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-322-2115 (TTY: 1-800-877-1113).
- XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-888-322-2115 (TTY: 1-800-877-1113).
- 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 1-888-322-2115 (TTY: 1-800-877-1113).
- ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-322-2115 (TTY: 1-800-877-1113).
- ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-322-2115 (TTY: 1-800-877-1113).
- ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-325-2115 (رقم هاتف الصم والبكم: 1-800-877-1113).
- ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-322-2115 (TTY: 1-800-877-1113).
- ဟ်သူဉ်ဟ်သး– နမ့်ကတိၤ ကညီ ကျိာ်အယိ. နမၤနှ်၊ ကျိာ်အတ်မၤစၢၤလၢ တလၫ်ဘူဉ်လၫ်စ့ၤ နီတမံၤဘဉ်သ့နှဉ်လီၤ. ကိး 1-888-322-2115 (TTY: 1-800-877-1113).
- ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-322-2115 (ATS: 1-800-877-1113).
- 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다 1-888-322-2115 (TTY: 1-800-877-1113) 번으로 전화해 주십시오.
- ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-888-322-2115 (መስማት ለተሳናቸው: TTY: 1-800-877-1113).
- OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-322-2115 (TTY - Telefon za osobe sa oštećenim govorom ili sluhom: 1-800-877-1113).
- ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ ។ 1-888-322-2115 (TTY: 1-800-877-1113).

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