EMPLOYEE CHANGE REQUEST FORM

Mail to: Aspirus Health Plan, Inc. • P.O. Box 1062, Minneapolis, MN 55440 • Fax 715-257-5995

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

Section 1 - Employee Information Changes

Employee Last Name	First Name	MI	ID Number
Spouse Last Name	First Name	MI	

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced/Separated

☐ **Name Change**	Change From	Change To	Reason For Change
	If Married, Spouse's Name	Date Of Marriage	Date of Divorce, If Applicable

☐ **Phone Number Change**	☐ Home ☐ Work ☐ Cell	Change To
☐ **Email Address Change**	Change To	

☐ **Address Change**	☐ Residence Address ☐ Mailing Address	Street		Apartment Number
		City	State	ZIP Code
☐ **Plan Change**	Change To			

Section 2 - Adding or Deleting Coverage for Spouse and Dependents

☐ **Addition Of Spouse Or Dependents**

Last Name	First Name	MI	Gender ☐ M ☐ F	Date Of Birth	Relationship To Member	Social Security #
Last Name	First Name	MI	Gender ☐ M ☐ F	Date Of Birth	Relationship To Member	Social Security #
Last Name	First Name	MI	Gender ☐ M ☐ F	Date Of Birth	Relationship To Member	Social Security #

☐ **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.

Section 3 - Notice of Special Enrollment Rights for Health Coverage cont.

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.

Name of Person Providing Assistance (if applicable) _____

Print Name_____

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/group-individual - Members - Understanding My Coverage

☐ **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 (if applicable):_____ Date _____