Employee Name (please print): _____

P.O. Box 91110
Sioux Falls, SD 57109
(605) 328-6800 • (800) 752-5863
Fax: (605) 328-6812
sanfordhealthplan.com

SANFORD HEALTH PLAN

Application for Simplicity/Sanford TRUE Small Group Health Insurance 2024

To be completed by Human Resource Representative

Group Name _____ Group/Division Name _____

Effective Date _____ Date of Hire _____

Reason for Enrollment: ❑New Hire ❑Open Enrollment ❑Special Enrollment Reason _____
(Please Specify)

Company Representative's Signature _____ Date: _____

Send originals to: PO Box 91110, Sioux Falls, SD 57109-1110

This section must be completed. Incomplete forms will be returned which may cause processing delays.

Help understanding this document is free.

If you would like it in a different (for example, a larger font size), please call us at (800) 752-5863 (*toll-free*) | TTY/TDD: 711

Help in a language other than English is also free.

Please call (800) 752-5863 (*toll-free*) | TTY/TDD: 711 to connect with us using free translation services.

1. Employee Information

First Name, M.I., Last Name	SS #[1]	Date of Birth (MM/DD/YY)	Age	Gender ☐ M ☐ F

Complete Mailing Address	City	State	Zip Code	County

Home Phone	Work Phone	Email Address

Marital Status ☐ Married ☐ Single ☐ Divorced/Separated	Primary Language Spoken ☐ English ☐ Spanish ☐ Other: _____

Family Physician	Clinic Name	City	State	Phone Number

2. Coverage Election

☐ YES – I am electing coverage

Sanford *Simplicity*: ☐ $500 ☐ $1,500 ☐ $1,750 ☐ $2,700 ☐ $3,200 HDHP ☐ $3,500 ☐ $3,750 HDHP ☐ $5,150 HDHP ☐ $5,250 ☐ $6,000 ☐ $7,050 HDHP

Sanford TRUE: ☐ $500 ☐ $1,500 ☐ $1,750 ☐ $2,700 ☐ $3,200 HDHP ☐ $3,500 ☐ $3,750 HDHP ☐ $5,150 HDHP ☐ $5,250 ☐ $6,000 ☐ $7,050 HDHP

NOTE: If you are electing a TRUE product, you must reside in a TRUE approved county. Check with your Employer or Sanford Health Plan for more details.

☐ NONE – I am declining coverage because I and/or my dependents have coverage through:

☐ Spouse's Group Health Plan

☐ Other, Explain: _____

[1] Health plans can request your Social Security Number, but cannot deny coverage based on lack of Social Security Number. For this application, we need your Social Security Number for Form 1095-B, which is provided to you in addition to being reported to the Internal Revenue Service.

Employee Name (please print): _____

3. Dependent Information

First Name/M.I./Last Name	Relationship (Spouse/ Dependent) [1]	Gender (M/F)	Date of Birth (MM/DD/YY)	SS #	If over 26, full time student (Y/N)	Medicare eligible[2] or disabled[3] (Y/N)

Do all of the dependent(s) listed above reside at the same address as the employee?
☐ Yes ☐ No If No, list dependent(s) name and address: _____

Provide additional information if answered 'Yes' above:

1. For North Dakota and Minnesota applicants: If the unmarried parent of the grandchild is a covered eligible dependent and both the parent and grandchild are primarily dependent on the subscriber. Grandchildren must reside with subscriber.
2. For South Dakota applicants: If the dependent is over age 26 and under age 30, and a full-time college student, please provide name of school/university, city and state:_____
3. For Iowa applicants: If dependent is a full-time college student, please provide name of school/university, city and state: _____
4. Name and Medicare number if applicable: _____
5. Is disabled person(s) eligible for Medicare? ☐ Yes ☐ No If Yes, please list names and Medicare number: _____

4. Other Insurance Information

a) Are you or any of your family members currently or have previously been enrolled with Sanford Health Plan?
☐ Yes ☐ No If Yes, who? List ID# _____

b) Will you or any of your family members be covered by another health policy after the effective date of enrollment with Sanford Health Plan?
☐ Yes ☐ No If Yes, you must complete the following information to coordinate benefits.

Person Insured	Employer of Insured	Insurance Company	Policy Number	Effective Date

5. Special Enrollment Notice

If you are declining enrollment for yourself or your dependents (including your spouse) 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 dependent's lose eligibility for that other coverage (or if the employer stops contributing toward you or your dependents other coverage). However, you must request enrollment within 31 days after you or your dependents' 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, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact our Customer Services Department at (605) 328-6800 or toll free at (800) 752-5863.

6. Genetic Information Nondiscrimination Act of 2008 (GINA)

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Employee Name (please print): _____

7. Michelle's Law

Federal law requires that we provide the following notice regarding Michelle's Law [Public Law 110-381]. Please note that changes in federal law may eliminate certain elements of Michelle's Law, and the Plan intends to provide continuing coverage of Eligible Dependents up to age twenty-six (26), irrespective of their student status, for Plan Years beginning on or after September 23, 2010.

A Dependent Child enrolled in, and attending, an accredited college, university, trade, or secondary school at least five (5) months each year will remain covered if the Dependent takes a medically necessary leave of absence from school or changes to part-time status. The leave of absence must:

1. Be medically necessary;
2. Commence while the child is suffering from a serious illness or injury; and
3. Cause the child to lose coverage under the plan.

Students are only eligible as long as they were covered by their parent's health insurance policy prior to diagnosis. Coverage will continue until the earlier of one year from the first day of the leave of absence or the date on which coverage would otherwise terminate because the child no longer meets the requirements to be an Eligible Dependent (e.g., reaching the plan's limiting age).

You must provide a signed, written documentation from the Dependent Child's treating Practitioner/Provider stating all of the following: 1) the Dependent Child is suffering from a serious illness or injury necessitating a medical leave of absence; 2) the treating Practitioner/Provider certifies such leave of absence is Medically Necessary; and 3) the dates when the Dependent will be either on a medically necessary leave of absence from school or will be changing to part-time status due to a serious illness or injury.

8. Conditions of Enrollment

I agree for myself and on behalf of my eligible dependents to the following conditions of enrollment in Sanford Health Plan (hereafter referred to as the Plan).

1. We will abide by the rules and regulations of the Plan.
2. We will be bound by the eligibility requirements as stated in the Member Handbook, benefits, deductibles, copayments, coinsurance, exclusions, limitations, and other terms of the health maintenance contract and certificate of coverage.
3. We will complete and submit to the Plan such concepts, releases and other assignments as are reasonably necessary for the Plan in accordance with its rights under the health maintenance contract and certificate of coverage, to coordinate with other group health benefit plans or group insurance policies. I shall cooperate with and assist the Plan with respect to such coordination of benefits.
4. We will pay any copayments, deductibles or coinsurance as is required by the health maintenance contract or certificate of coverage directly to those providers who provide the health care services.
5. We acknowledge that we will be personally liable to the Plan for the usual and customary cost of any Health Care Services received during a time we are not eligible for coverage under the Certificate of Coverage.

9. Signature

On behalf of myself and my eligible dependents listed above, I hereby agree to the conditions of enrollment attached hereto. If applicable, my employer is authorized to deduct from my earnings the necessary premium contributions, if any, required of me.

X Signature of Employee _____ Date: _____

Health Plan Use Only

Mark category after audit is complete. Circle if information is incorrect and return to enrollment processor for corrections.

☐ Social Security #	☐ Dependent student on review
☐ Group #	☐ Address
☐ Effective date	☐ Date of birth
☐ Date of hire	☐ Other insurance information
☐ Name spelling	☐ Other: _____
☐ Sex (male/female)	

Auditor: _____ Date: _____

Processor: _____ Date: _____