Enrollment Application for Avera *MyPlan* Individual Health Insurance

You are eligible to apply if:

- You are a full-time South Dakota resident,
- You are a United States citizen and
- You are not eligible for Medicare.

How to Apply:

- Application must be completed by printing all information in black or blue ink. (Applications completed in pencil will not be accepted.)
- If this application is for Self + Spouse, the applicant must be the youngest spouse
- If this application is for Child(ren) Only, the applicant must be the youngest child. Please list the youngest child in Section 2, Applicant Information. Additional children should be listed in Section 4, Dependent Information.
- If the applicant is under age 18, the signature and relationship of a parent or legal guardian or proof of emancipation is required.
- We must receive this application within 15 days of the date you sign it.

Policy Effective Date will depend upon when Avera Health Plans receives the application, as follows:

Applications received by Avera Health Plans	Effective Date
During Annual Open Enrollment Period *(between July 1 and August 14)*	**The first of the month after the application is received.** Example: Application received on July 10 will have a coverage effective date of August 1.
Outside of Annual Open Enrollment Period *(between August 15 and June 30)*	**Varies depending upon date the application is signed and dated, as follows:** • Applications signed and dated on the first day through the 15th day of the month, will become effective the first day of the following month. • Applications signed and dated on the 16th day through the end of the month, will become effective the first day of the month following 30 days from the date of your signature. Example: If you sign and date your application January 10, your policy will be effective February 1. If you sign and date your application January 17, your policy will be effective March 1.)

NOTE: The receipt date of the application determines whether it is considered inside or outside of the annual Open Enrollment period.

Application Checklist:

- ☐ Indicate which type of *MyPlan* policy you are applying for (Section 3, Coverage Election)
- ☐ Indicate which *MyPlan* Benefit Plan you are requesting (Section 5, Benefit Plan Election)
- ☐ Indicate if you are applying for optional benefits (Section 5, Benefit Plan Election)
- ☐ Complete the Authorization for Automatic Account Withdrawal (EFT/ACH) form and enclose a copy of a voided check or savings deposit slip if you would like to have your premium automatically deducted from a checking or savings account. If you are planning to use a business account to pay for your Avera *MyPlan* premiums, you must be able to answer “NO” to both questions in Section 6, Monthly Payment Options.
- ☐ Answer each of the health and medication questions. (Section 10, Health Questionnaire and Section 11, Medication Questionnaire)
- ☐ Attach a copy of your Certificate of Creditable Coverage as you may be eligible for credit toward any pre-existing condition limitation applicable under our plan. NOTE: If you have not received your Certificate of Creditable Coverage you may submit it at a later date.
- ☐ The applicant must initial and date any changes made on this application. The applicant must sign and date this application on the back. (Section 12, Agreement Section)

IMPORTANT: Please refer to Section 9, Failure to Disclose section before signing this application.

FOR OFFICE USE ONLY
Tracking # ________________
Effective Date: _____________

INDIVIDUAL HEALTH INSURANCE ENROLLMENT APPLICATION WITH Avera MyPlan

ELIGIBLITY

☐ I am a full-time South Dakota resident,
☐ I am a United States Citizen and
☐ I am not eligible for Medicare.

1. MEMBERSHIP INFORMATION

☐ New Enrollment (complete all sections) ☐ Change Existing Coverage

2. APPLICANT INFORMATION

If this application is for:

- Child(ren) Only coverage, the Applicant must be the youngest child.
- Self + Spouse coverage, the Applicant must be the youngest spouse.

Social Security #: *(required for internal use only)* ☐☐☐ – ☐☐ – ☐☐☐☐ **Date of Birth:** ____________________

Applicant Name (Last, First, M.I.): ____

Street Address: ______________________________ **Billing Address:** ______________________________

City: ______________________ **State:** __________ **ZIP Code:** __________ **County:** ______________________

Home Phone: (_____) _____ - _______ **Work Phone:** (_____) ______ - _______ **Email Address:** ______________________

Gender: ☐ Male ☐ Female **Height:** _____ FT_____ IN **Weight:** ______ LBS **Marital Status:** ☐Single ☐Married ☐Divorced

Full-time Student? ☐ Yes ☐ No **Disabled?** ☐ Yes ☐ No **Any tobacco use in the last 12 months?** ☐ Yes ☐ No**

Best time to reach you from 8 a.m. to 5 p.m. CT, Monday through Friday: ______________________________

Primary Care Physician: ______________________________ **Clinic Name:** ______________________

City: ______________________________ **State:** ______ **Phone Number:** (______) ______ - __________

3. COVERAGE ELECTION

This request for coverage is for (Choose One)
☐ Self ☐ Self + Spouse ☐ Self + Child(ren) ☐ Child(ren) Only ☐ Family

4. DEPENDENT 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 (M/F)	Relationship	Birth Date * (Mo/Day/Yr)	Social Security Number	Height	Weight	Any tobacco use in the past 12 months?
02	Spouse	☐ M ☐ F	Spouse					☐ Yes ☐ No**
03	Dependent	☐ M ☐ F						☐ Yes ☐ No**
04	Dependent	☐ M ☐ F						☐ Yes ☐ No**
05	Dependent	☐ M ☐ F						☐ Yes ☐ No**
06	Dependent	☐ M ☐ F						☐ Yes ☐ No**

*If the dependent is 26 through 29 years old and enrolled in and attending an accredited college, university, or trade or secondary school on a full time basis, he or she must remain a continuous full-time student through the age of 29 and not have other creditable coverage to be eligible for this plan. Proof of full-time student status must be provided for the enrollment process. Please note the name of the school your dependent attends and include a copy of their enrollment record from the school's registrar.

School Name: ______________________________ City: ______________________________State: ______ ZIP: __________

**If you answered "No," you are eligible for a special tobacco non-user rate. If this status changes, you must notify us immediately. We may require you to recertify this status in the future. If we determine within the initial two years that this status is incorrect, we may start applying the tobacco user rates on the first of the month following receipt of this information.

4. DEPENDENT INFORMATION Continued…

- Do all of the dependent(s) listed in Section 4 reside in the same city and state as the applicant? ☐ Yes ☐ No

  If No, list dependent(s): ______________________________

  City: ______________________________ State: __________ ZIP Code: ____________
- Are any dependents listed in Section 4 disabled and eligible for Medicare? ☐ Yes ☐ No If Yes, list Dependent(s): ________________
- Do you have a Qualified Medical Child Support Order (QMCSO)? ☐ Yes ☐ No If Yes, please attach a copy to this application.

In order to complete the underwriting process, we may need to contact you. Contact information is required for the applicant and each individual age 18 and older, if different than the applicant's contact information. Please indicate the best method and time to contact you.

List Names		Contact Information
02	Spouse	☐ Phone: (________) ________—________ ☐ Email: ______________________ ☐ Fax: (________) ________—________ ☐ Mail Best time to reach you from 8 a.m. to 5 p.m. CT, Monday through Friday: ______________ Primary Care Physician: ____________________ Phone: (________) ________—________
03	Dependent	☐ Phone: (________) ________—________ ☐ Email: ______________________ ☐ Fax: (________) ________—________ ☐ Mail Best time to reach you from 8 a.m. to 5 p.m. CT, Monday through Friday: ______________ Primary Care Physician: ____________________ Phone: (________) ________—________
04	Dependent	☐ Phone: (________) ________—________ ☐ Email: ______________________ ☐ Fax: (________) ________—________ ☐ Mail Best time to reach you from 8 a.m. to 5 p.m. CT, Monday through Friday: ______________ Primary Care Physician: ____________________ Phone: (________) ________—________
05	Dependent	☐ Phone: (________) ________—________ ☐ Email: ______________________ ☐ Fax: (________) ________—________ ☐ Mail Best time to reach you from 8 a.m. to 5 p.m. CT, Monday through Friday: ______________ Primary Care Physician: ____________________ Phone: (________) ________—________
06	Dependent	☐ Phone: (________) ________—________ ☐ Email: ______________________ ☐ Fax: (________) ________—________ ☐ Mail Best time to reach you from 8 a.m. to 5 p.m. CT, Monday through Friday: ______________ Primary Care Physician: ____________________ Phone: (________) ________—________

Answer the question below for each individual under age 19 who is applying for coverage.

1. ☐ Yes ☐ No For applications received by Avera Health Plans between July 1 and August 14 (during the annual open enrollment period), is anyone listed on the application (under the age of 19) **enrolled** on a Group Health plan? If yes, the individual(s) enrolled in group coverage is not eligible for the policy.

   If yes, list each dependent who is eligible or enrolled in another group health plan: ______________________

5. BENEFIT PLAN ELECTION

Choose one plan. (If more dependents, attach a sheet of paper, sign and date it.)

☐ **Avera *MyPlan* $5000**

Please check the benefit options you want for each dependent listed in Section 4.

	Policyholder	Dependent(s):	02	03	04	05	06
Dental	☐	Dental	☐	☐	☐	☐	☐
Vision	☐	Vision	☐	☐	☐	☐	☐
Maternity	☐	Maternity	☐	☐	☐	☐	☐

☐ **Avera *MyPlan* $5000 with Co-Pay**

Please check the benefit options you want for each dependent listed in Section 4.

	Policyholder	Dependent(s):	02	03	04	05	06
Dental	☐	Dental	☐	☐	☐	☐	☐
Vision	☐	Vision	☐	☐	☐	☐	☐
Maternity	☐	Maternity	☐	☐	☐	☐	☐

Note: A benefit option can only be canceled after it has been in effect for 12 consecutive months. There is a 12-month waiting period to reapply for the cancelled benefit option. Benefit option(s) will be cancelled automatically when you terminate your Individual Health Insurance Policy.

6. MONTHLY PAYMENT OPTIONS

If you are planning to use a business account to pay for your Avera *MyPlan* premiums, please answer questions 1 and 2 below:

1. Are there any other employees in addition to you? ☐ Yes ☐ No
2. Will your premium payments for this coverage be deducted on your federal income tax return in a manner other than the special health insurance deduction available to self-employed persons? ☐ Yes ☐ No

If you answered “Yes” to either question above, premiums cannot be withdrawn from a business account. You will need to use a personal bank account to pay your premiums.

Choose one option:

☐ **Automatic Account Withdrawal**

If you select this monthly payment option, then you must complete an Avera *MyPlan* Authorization for Automatic Account Withdrawal (EFT/ACH) Form (found on the last page of the application). Enclose a voided check or savings deposit slip showing a preprinted account number, your name and the name and address of your financial institution.

☐ **Direct Bill (**Payment by Check**)**

7. PREVIOUS COVERAGE

Does any person named on this application have previous health care coverage of 12 months or more without a lapse of 63 days? ☐ Yes ☐ No

If Yes, the following information must be completed to determine a waiting period or coordination of benefits. Certificates of Creditable Coverage from your previous carrier(s) should be attached to this application. If you have not received your Certificate of Creditable Coverage you may submit it at a later date. If this section is not completed, an assumption will be made that there was no prior coverage and permissible pre-existing limitations will apply.

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	__________	__________

8. OTHER INSURANCE COVERAGE

A. Are you currently or have you previously been enrolled with Avera Health Plans? ☐ Yes ☐ No

If Yes, list Member ID Number: ______________________

B. Will you or any of your family members 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:

Person Insured: ______________________________ Employer of Insured: ______________________________

Name of Insurance Company: ______________________________ Policy Number: ______________________

Effective Date: ______________ List covered family members: ____

C. Is anyone named on the application eligible for Medicare / Medicaid? ☐ Yes ☐ No

If Yes, list Name(s): ______________________________ Medicare or Medicaid Number(s): ______________________________

9. FAILURE TO DISCLOSE

I represent that all information listed on this application and any accompanying documents is/are complete and accurate to the best of my knowledge. I understand that my answers to the questions on this form will be used to determine eligibility for coverage and is the basis on which my premium rate may be determined. I understand that should my health condition or the health condition of any dependent on this application change prior to the effective date of coverage, or a condition arises that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment, regardless of the date I signed the application, I have a responsibility to notify Avera Health Plans of such change(s) by sending this information in writing to: Avera Health Plans, Inc. • 3816 S. Elmwood Ave., Suite 100 • Sioux Falls, SD 57105-6538

I also realize that such notification may result in recalculation of premium, a declination of coverage or a rescission of coverage. I further understand that if I intentionally misrepresent or conceal a fact and coverage would have been denied or charged a higher premium, it could provide the basis to refuse or rescind coverage and to refund any premiums paid as though coverage had never been in force. If an applicant intentionally misrepresents or conceals a fact and coverage would have been denied or charged a higher premium because the claim was incurred during the first two years of the policy, a review by Avera Health Plans will occur.

10. HEALTH QUESTIONNAIRE

If anyone listed on this application has ever had any indications, signs, symptoms, diagnosis, treatment or used any prescription or non-prescription medications, treatments or devices for the following conditions, please place an "X" in the box under the column marked "Yes" to the right of the condition described. If not, please place an "X" in the column marked "No" to the right of the condition described. You must provide additional information below about each condition marked "Yes" or your application will be returned. If you change your answer, you must initial the change.

HIGH RISK HEALTH CONDITIONS

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
AIDS / HIV	☐	☐	Crohn's Disease	☐	☐	Joint Degeneration	☐	☐	Parkinson's Disease	☐	☐
Alzheimer's Disease	☐	☐	Cystic Fibrosis	☐	☐	Kidney Diseases – Chronic	☐	☐	Peripheral Neuropathy	☐	☐
Amyotrophic Lateral Sclerosis (ALS)	☐	☐	Diabetes (All Types)	☐	☐	Leukemia	☐	☐	Peripheral Vascular Disease	☐	☐
Anemia – Aplastic or Sickle Cell	☐	☐	Diabetic Retinopathy	☐	☐	Lipodystrophy	☐	☐	Pregnant or Expectant Parent	☐	☐
Aneurysm	☐	☐	Diverticulitis	☐	☐	Liver Problems	☐	☐	Pulmonary Fibrosis	☐	☐
Angioplasty	☐	☐	Emphysema or Chronic Lung Disease	☐	☐	Lupus	☐	☐	Pulmonary Hypertension	☐	☐
Blood Disease	☐	☐				Macular Degeneration	☐	☐	Quadriplegia	☐	☐
Brain Abscess	☐	☐	Encephalitis	☐	☐	Major Burns or Skin Trauma	☐	☐	Rheumatoid Arthritis	☐	☐
Cancer Type:	☐	☐	Epilepsy	☐	☐	Major Heart Disorder	☐	☐	Scleroderma	☐	☐
			Gastric Bypass or Weight Loss Surgery	☐	☐	Multiple Sclerosis (MS)	☐	☐	Sinusitis – Chronic	☐	☐
						Muscular Dystrophy	☐	☐			
Carcinoid Syndrome	☐	☐	Guillain Barre Syndrome	☐	☐	Neuromuscular Disorder	☐	☐	Spina Bifida	☐	☐
Cardiac Bypass	☐	☐	Heart Attack	☐	☐	Organic Brain Syndrome; ex. Dementia	☐	☐	Spinal Abscess	☐	☐
Chronic Hepatitis; ex. Hepatitis C	☐	☐	Heart Valve Disorder	☐	☐		☐	☐	Transplant Type:	☐	☐
Cirrhosis	☐	☐	Hemiplegia	☐	☐	Osteoporosis	☐	☐	Ulcerative Colitis	☐	☐
Congenital Disorders	☐	☐	Hemophilia	☐	☐	Pancreatitis	☐	☐	Other:	☐	☐
Coronary Artery Disease	☐	☐	Hydrocephalus	☐	☐	Paraplegia	☐	☐			

OTHER MEDICAL CONDITIONS

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Acid or Esophageal Reflux (GERD)	☐	☐	Brain, Spine or Nerve Problem	☐	☐	Glaucoma	☐	☐	Pap Smear, Abnormal	☐	☐
Acne	☐	☐	Breast Problem	☐	☐	Gout	☐	☐	Pituitary Dwarfism	☐	☐
Alcohol / Substance Abuse	☐	☐	Broken Bone or Dislocation	☐	☐	Headaches	☐	☐	Poisonings	☐	☐
Allergies ex. Hay Fever	☐	☐	Bursitis or Tendinitis	☐	☐	Hernia Type:	☐	☐	Previous Pregnancy	☐	☐
Anemia / Blood Disease	☐	☐	Carpal Tunnel Syndrome	☐	☐	High Blood Pressure	☐	☐	Prostate Problem	☐	☐
Anxiety	☐	☐	Cataract	☐	☐	High Cholesterol	☐	☐	Rectal Problem	☐	☐
Arthritis or Rheumatism Type:	☐	☐	Colon Polyps	☐	☐	Irregular Heartbeat; ex. Atrial Fibrillation	☐	☐	Sexually Transmitted Disease	☐	☐
									Skin Problem	☐	☐
Asthma or Breathing Problem	☐	☐	Congenital Disease or Problem	☐	☐	Jaw Problem; ex. TMJ, TMD	☐	☐	Sleep Problem; i.e. Apnea	☐	☐
Attention Deficit Hyperactivity Disorder (ADHD / ADD)	☐	☐	Connective Tissue Disorders	☐	☐	Kidney Problem	☐	☐	Stroke	☐	☐
Autism	☐	☐	Depression	☐	☐	Loss of Limb(s)	☐	☐	Surgery	☐	☐
Back, Spinal, or Neck Problem	☐	☐	Ear, Nose, Throat, or Tonsil Problem	☐	☐	Major Injury Type:	☐	☐	Thyroid Problem	☐	☐
Bipolar Depression	☐	☐	Eating Disorder	☐	☐	Menstrual or Pelvic Problem	☐	☐	Tuberculosis or Positive TB Test	☐	☐
Bladder / Urinary Problem	☐	☐	Epilepsy / Seizure	☐	☐	Meningitis	☐	☐	Tumor, Growth or Cyst	☐	☐
Bleeding Problem	☐	☐	Eye or Retina Problem	☐	☐	Mental, Nervous or Emotional Problem	☐	☐	Ulcer	☐	☐
Bone Disease or Deformity	☐	☐	Fertility Problem	☐	☐				Varicose Veins	☐	☐
Bowel Problem; ex. Irritable	☐	☐	Fibromyalgia	☐	☐	Migraines	☐	☐	Vein or Artery Disease	☐	☐
Bowel Syndrome, Diverticulosis	☐	☐	Gallbladder Problem	☐	☐	Pancreatic Problem	☐	☐	Weight Problem; ex. Over or Under Weight	☐	☐

10. HEALTH QUESTIONNAIRE (Continued)

Is there any future surgery, diagnostic testing, or recommended or scheduled for medical treatment for anyone listed on the application? ☐ Yes ☐ No

If Yes, please describe: ____

Are you, the policyholder, or any of your dependents currently pregnant, an expectant parent, otherwise responsible for a pregnancy, or in the process of adoption or surrogacy with anyone whether or not that other person is also applying for coverage on application? ☐ Yes ☐ No

If Yes, Applicant Name:______________________________ Due Date or Adoption Date: ____________

If you answered "Yes" to any of the questions in Section 10 or you know of other conditions/illnesses not listed in the previous section, please provide the following information: (If more space is needed, attach a sheet of paper, sign and date it.)

Individual	Name of Condition	Date Diagnosed	Date of Last Treatment	Type of Treatment (examples: medications, therapy, doctor visits, planned surgery)	Treating Provider	Ongoing/ Follow-up Treatment
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No

Has an insurance company refused or restricted health coverage on any person listed on the application? ☐ Yes ☐ No
If Yes, please complete the following:

Individual	Insurance Company Name	Reason for Refusal/Restriction of Coverage	Date of Refusal/Restriction

11. MEDICATION QUESTIONNAIRE

- Is any person listed on this application currently taking prescribed or over-the-counter medication? ☐ Yes ☐ No
- Has any person taken medications within the past 12 months? ☐ Yes ☐ No
- Has any person been instructed by a provider to start taking medications? ☐ Yes ☐ No

If you answered Yes to any of the above, provide additional detail below. Chart is continued on the next page. (If more space is needed, attach a sheet of paper, sign and date it.)

Individual	Medication Name	Dosage	Frequency	Reason for Medication	Prescriber's Name	Still Taking?
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No

Individual	Medication Name	Dosage	Frequency	Reason for Medication	Prescriber's Name	Still Taking?
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No

AUTHORIZATION TO RELEASE INFORMATION TO AVERA HEALTH PLANS

By signing this application, I authorize any consumer reporting agency, medical information bureau, pharmacy benefit manager, 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 Benefit Summary) 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.

I understand that I can revoke this authorization at any time by giving written notice to Avera Health Plans at 3816 S. Elmwood Ave., Suite 100, Sioux Falls, SD 57105-6538. I also understand that my revocation will not affect the rights of any individual who has acted in reliance on the authorization prior to receiving the notice of my revocation. I understand that there is a possibility of redisclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

If this Avera *MyPlan* individual health insurance policy is intended to replace my existing health insurance, I understand the following:

a. Health conditions which I now have (known as "pre-existing conditions") may not be immediately or fully covered under the new policy or certificate of coverage. This could result in denial or delay of payment for a claim under the new policy or certificate of coverage, whereas the same claim might have been paid under your present policy.

b. I may want to get the advice of my present insurer or insurance agent regarding the replacement of my current policy. This is not only my right, but it is also in my best interest to make sure I understand all the relevant factors involved in replacing my present coverage.

c. If, after considering the above items, I still wish to terminate my present policy and replace it with the Avera *MyPlan* coverage, the information I have provided about my medical history is accurate to the best of my knowledge. I agree to accept responsibility for omissions regarding my failure to disclose existing or past conditions. Failure to include all vital medical information on an application may provide a basis for Avera Health Plans to deny payment for my claims submitted and to refund my premium as though my policy or certificate had never been in force. After the application has been completed and before I sign it, I have reread it carefully to be certain that all information is accurate and truthful.

12. AGREEMENT AND CERTIFICATION

I certify that I am legally authorized to apply for coverage for myself and on behalf of all other persons named in this application. I understand that I am applying for coverage as indicated on this application, providing the specified individual health information. I further understand that coverage applied for will not start until this application and the appropriate premium payment amount are received and accepted by Avera Health Plans, an effective date of coverage is established, and Avera Health Plans notifies me in writing of approval of coverage**.**

I certify that I have carefully and fully read the Agreement and Certification language and the Notice to Applicant Regarding Replacement of Accident and Sickness Insurance section. I have confirmed with all persons named in this application that my signature is binding to secure coverage. I have further confirmed with all persons named in the application that in the event I am not eligible for or removed from the coverage and/or the family coverage is divided into multiple policies, my signature is binding to secure coverage. Any payment will be held until the application process is complete.

Applicant Signature: ______________________________ Date: ______________

Parent/Legal Guardian Signature (if applicant is a minor): ______________________ Date: ______________

NOTE: If guardian, please provide proof of guardianship.
Parent/Legal Guardian Name (please print): ______________________

Relationship: ______________________

☐ I have reviewed the checklist on the cover page and have completed all necessary sections of this application.

Agent's Signature: ______________________ Date: ____________

Agent Name (please print): ______________________ Agency Name: ______________________

Avera Health Plans

Avera *MyPlan*
Authorization for Automatic Withdrawal (EFT/ACH)

INSTRUCTIONS

To pay your Avera *MyPlan* premium by automatic withdrawal:

- **Complete, sign and date this authorization form.**
- **Attach a pre-printed voided check or savings deposit slip to this form.**
- Return completed form to Avera Health Plans.
- Retain a copy of this form for your files.

Automatic withdrawals, also known as electronic funds transfer (EFT), are processed through the Automated Clearing House (ACH) network.

Mail completed form to:
Avera Health Plans, Inc.
Attn: Finance Department
3816 S. Elmwood Ave., Suite 100
Sioux Falls, SD 57105-6538

OR

Fax completed form to:
1 (866) 574-2217
Attn: Finance Department

If you have any questions concerning your authorization for automatic withdrawal, please contact our Service Center at **(605) 322-4545** or toll-free at **1 (888) 322-2115**.

MONTHLY AUTHORIZATION FOR AUTOMATIC WITHDRAWAL

NOTE: You will not receive a monthly invoice when automatic withdrawal is in effect.

☐ **Start Automatic Withdrawal** – I want Avera Health Plans to withdraw my premiums from the checking or savings account designated below. This signed form must be received at least 20 days before my next premium due date, or I must include payment for the current premium due.

☐ **Change Automatic Withdrawal** – I want to change the checking or savings account information for the automatic withdrawal of my premiums.

Subscriber Name (please print):

Subscriber or Social Security Number:

Name of Financial Institution:	Telephone Number for Financial Institution	
Address of Financial Institution:	( ) –	
City:	State:	Zip Code:

Financial Institution Routing/Transit #:
(Nine digits printed on the bottom of your check between these ⑆ characters.)

____ ____ ____ ____ ____ ____ ____ ____ ____

Attach a voided check <u>or</u> savings deposit slip showing a pre-printed account number, your name, and the name and address of your financial institution.

☐ Checking Account # ____

-or-

☐ Savings Account # ____

If you are planning to use a business account to pay your Avera *MyPlan* premiums:

1. Are there other employees in addition to you? ☐ Yes ☐ No
2. Will your premium payments for this coverage be deducted on your federal income tax return in the manner other than the special health insurance deduction available to self-employed persons? ☐ Yes ☐ No

If you are unable to answer "No" to both questions above, you will need to use a personal banking account to pay your Avera *MyPlan* premiums.

I hereby authorize Avera Health Plans and the financial institution named above to initiate automatic ACH debit entries (and/or corrections to previous debits) from the above designated checking or saving account for payment of my Avera *MyPlan* premiums. I understand that the amount withdrawn may vary due to premium rate changes as a result of annual policy renewal and/or other change(s) requested, such as, but not limited to, adding and removing dependents, benefit options, etc. Any changes in my premium will automatically be deducted from my designated bank account and I am responsible for monitoring these changes.

This authorization includes premium withdrawals and any changes to that amount. If I wish to make a stop payment request, I must call or provide my bank with written notice not less than three business days before a scheduled withdrawal. If I call my bank to stop payment, I may be required to provide a written notice within 14 days. I will be responsible for any fee(s) assessed by my bank. This authorization supersedes and replaces any previous authorization given by me for automatic premium withdrawal.

This authorization is to remain in effect until I notify Avera Health Plans and my financial institution in writing to cancel it; or upon termination of coverage. Automatic withdrawals are processed on or about the fifth day of every month. If the fifth day is on a weekend or holiday, the automatic withdrawal will be processed on the next business day. I may change or cancel my automatic withdrawal at any time; however, we must receive the proper notification form at least 20 days before my next scheduled withdrawal. I understand it is my responsibility to have sufficient funds in my designated bank account to cover the full premium due. If the necessary funds are not in my designated account on the draft due date, it may result in termination of coverage. I agree to promptly notify Avera Health Plans of any change to the banking information I have provided.

AUTHORIZED SIGNATURE OF BANK ACCOUNT HOLDER	NAME ON BANK ACCOUNT – PLEASE PRINT	DATE
X		