ascend
TO WHOLENESS HEALTHCARE PLANS

2018 Healthcare Plan

OPEN ENROLLMENT APPLICATION

Employee Instructions:

Complete the entire application except the employer section. Return your completed application to your employer within the open enrollment period. If you don't select a Plan and return this application to your employer within the Open Enrollment period you will NOT have coverage for the upcoming year. Only add people you want added to the plan.

PLAN COVERAGE SELECTION:

EMPLOYEE ONLY: ☐ | EMPLOYEE + SPOUSE ONLY: ☐ | EMPLOYEE + CHILDREN: ☐ | FAMILY: ☐

PLEASE USE YOUR FULL LEGAL NAME IN FILLING OUT THIS FORM.

EMPLOYEE INFORMATION:

FIRST (GIVEN) NAME:		MIDDLE INITIAL:		LAST (SURNAME) NAME:	
EMAIL ADDRESS:		WORK PHONE:		HOME PHONE:	
MARITAL STATUS:		SSN#:	SEX:	BIRTHDATE:	
ADDRESS 1:					
ADDRESS 2:		CITY:		STATE:	ZIP CODE:

SPOUSE INFORMATION:

FIRST (GIVEN) NAME:		MIDDLE INITIAL:		LAST (SURNAME) NAME:	BIRTHDATE:
EMAIL ADDRESS:		SSN#:	SEX:	EMPLOYED: ☐ YES ☐ NO	
OTHER INSURANCE: ☐ YES ☐ NO	DEPENDENTS COVERED: ☐ YES ☐ NO	POLICY HOLDER ID#:		EFFECTIVE DATE:	

DEPENDENT INFORMATION:

RELATIONSHIP	FIRST NAME	M.I.	LAST NAME	BIRTHDATE	OTHER INSURANCE	SSN#
☐ SON ☐ DAUGHTER					☐ YES ☐ NO ☐ PRIMARY ☐ SECONDARY	
☐ SON ☐ DAUGHTER					☐ YES ☐ NO ☐ PRIMARY ☐ SECONDARY	
☐ SON ☐ DAUGHTER					☐ YES ☐ NO ☐ PRIMARY ☐ SECONDARY	
☐ SON ☐ DAUGHTER					☐ YES ☐ NO ☐ PRIMARY ☐ SECONDARY	

MAKE YOUR SELECTION

FOR YOUR MEDICAL PLAN OPTION BELOW

(REQUIRED)

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☐ Accelerate Plan

The Accelerate Plan is designed to encourage and support the health and wellness of participating Plan employees and their family members. **For the 2018 plan year, there are no activity points required for the Accelerate Plan**. To qualify for the Accelerate Plan for 2019, you and your enrolled spouse are required to do the following in 2018:

- Participate in Care Management and/or Health Coaching Services if you or your spouse are identified by the health plan as someone who would benefit from these services.
- If you want to continue in the Accelerate Plan in 2019, you must complete certain requirements in 2018. See "All members" section below for the Accelerate Plan requirements for 2019.

By enrolling in the Accelerate Plan Program, you and your spouse are agreeing that you will satisfy the above requirements, along with wellness and activity point requirements. If you do not satisfy the requirements of completing the wellness assessment (60 points), biometric screening (60 points), and earning an additional 80 activity points for a total of 200 Ascend to Wholeness points in 2018, you and your spouse will be removed from the Accelerate Plan for 2019. Likewise, if your enrolled spouse does not satisfy the requirements of completing the wellness assessment (60 points), biometric screening (60 points), and earning an additional 80 activity points for a total of 200 Ascend to Wholeness points in 2018, you and your spouse will be removed from the Accelerate Plan for 2019.

If you or your spouse are identified as someone who would benefit from care management and/or health coaching and you do not meet the care management and/or health coaching requirements, then you and your spouse (and family) will not be eligible for the 2019 Accelerate Plan year.

☐ Access Plan

There are no wellness requirements to participate in the Access Plan. The Access Plan has higher deductibles, co-payments and co-insurance than the Accelerate plan. If you choose the Access plan now, you will not be able to move into the Accelerate Plan until 2019, even if you later choose to participate in the health-promoting activities outlined above.

☐ Decline Coverage

I understand that I am an employee eligible to participate in the Ascend to Wholeness Healthcare Plans for Employees of the Seventh-day Adventist Church organizations working in the United States ("Plan"). By selecting this option, I hereby (1) decline coverage under the Plan; and (2) certify to my employer that I have health plan or health insurance coverage from another source, such as a health plan sponsored by the employer of my spouse or parent, or a federal plan, such as Medicare or Medicaid. I have attached proof of such other coverage to this application.

By declining coverage for myself as an employee, I understand that my spouse and dependent children ("Dependents") are not eligible for coverage under the Plan. I understand that my ability to enroll myself and my Dependents in the Plan at a later date may be restricted to certain time periods, such as (1) an open enrollment period of my employer; and/or (2) the special enrollment periods described in the Plan.

I also acknowledge, represent and agree that:

- Since I am eligible for Plan coverage, my tax dependents and I will not qualify for any federal subsidy (premium tax credit) available for health insurance purchased at a Health Insurance Marketplace (for more information about the Health Insurance Marketplaces, visit www.healthcare.gov);
- I am signing this form voluntarily and I am not required by my employer or the Plan to sign this application; and
- I have not been given and will not be given any incentive, reward or consideration by my employer or the Plan for signing this application.

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Employee Authorization and Certification

I have received a copy of the Health Plan Guide, Plan Comparison and have access to other documents concerning open enrollment at http://ascendtowholeness.org I have read and understand the open enrollment materials and my rights to choose the Plan I believe is best for me. I understand there is a medical Preferred Provider Organization (PPO) that must be used for non emergency situation in order for the Plan to respond. I recognize there are certain requirement for me and my covered spouse, if applicable, in the areas of enrollment, health coaching, prior authorization and others. I recognize I have full access to the plan document by no later than January at the http://ascendtowholeness.org website, and that it is my responsibility to be in compliance with the Plan.

I agree that my employer may withhold from my paycheck the employee contributions that are required for the plan coverages that I have elected above, including enrollment in the Accelerate Plan. I understand that there may be employee contributions, for all plan coverages, including coverage for full time employees, and that I have been given access to employee contribution rates. I further understand and agree that my paycheck withholding authorization will continue into future years if I remain covered under my employer's group health plan.

I understand that if the information is not complete and correct, this coverage could be retroactively terminated.

I authorize all providers of healthcare to furnish all records pertaining to medical history, services, and rendered treatment given as pertains to evaluation of enrollment application and/or claims. This authorization will become effective immediately and will remain in effect as long as necessary to enable Adventist Risk Management, Inc. to process the application and/or claims.

I agree to notify my employer of any changes in family status or eligibility of family members. Failure to notify my employer of any status changes will authorize my employer to ask Adventist Risk Management, Inc. to deny payments of future claims and ask for collection of past paid claims for ineligible spouse or dependents.

I certify that the above information is complete and correct.

We take your privacy and confidentiality seriously
As your health plan administrator, Adventist Risk Management and its partners adhere to all HIPAA privacy regulations. No personally identifiable health information will be shared with your employer, including the Human Resources department, managers, supervisors or other non-health plan employees. Your employer receives only aggregated statistics, stripped of identifying information.

EMPLOYEE SIGNATURE:		DATE (MM/DD/YYYY):	

EMPLOYER SECTION - FOR OFFICE USE ONLY

NAME		EFFECTIVE DATE	USE (P) FOR PRIMARY AND (S) FOR SECONDARY			
		(MM/DD/YYYY)	MEDICAL	DENTAL	VISION	Rx
EMPLOYEE						
SPOUSE						
DEPENDENT CHILD #1						
DEPENDENT CHILD #2						
DEPENDENT CHILD #3						
DEPENDENT CHILD #4						

RECEIVED ON (MM/DD/YYYY):		DEPARTMENT NAME:	
COVERAGE CODE:		DEPARTMENT #:	
COMMENTS:			
EMPLOYER SIGNATURE:		DATE (MM/DD/YYYY):	
SIGNATORY NAME:			
SIGNATORY TITLE:			