Application for
Individual Health Insurance

An Individual Sanford Health Plan Product

How to Apply:

Instructions

- Applicant must reside and maintain a street address in South Dakota and be a United States citizen or have a permanent green card to be eligible for this plan.
- Complete application in black or blue ink. Pencil will not be accepted.
- Incomplete applications will be returned.
- If this application is for children only, the primary applicant must be the youngest child.
- Sanford Health Plan must receive this application within 14 calendar days from the date of signature.

Policy Effective Date

- Requested effective date can be no earlier than the day following the signature date and no later than 60 days from the date of signature.
- If an effective date is not selected, the effective date will be the first of the month following the approval date.
- Applications for a newborn (age 0-6 months) listed as the primary applicant can request an effective date no earlier than the first of the month following the signature date and no later than 60 days from the date of signature.
- Your policy becomes effective at 12:00 a.m. (midnight) CST, with the date listed on your application and enrollment letter. Coverage begins on the date your policy goes into effect unless you are in the hospital or other inpatient facility. In that case, your coverage begins the day after your discharge from the hospital or other inpatient facility.
- Changes made to an existing policy are generally effective the first of the month following the signature date.

Application Checklist

- ❐ Indicate which benefit plan you are applying for (See Section 2, *Coverage Election*).
- ❐ Include an ACH form and **voided check** for premiums to be automatically deducted from a checking or savings account. Upon application, the state of South Dakota requires Sanford Health Plan to take reasonable steps to ensure that premiums are not paid by an employer. All business checks received require proof of sole proprietorship.
- ❐ Answer each health question in Sections 6a through 6e.
- ❐ The applicant must initial and date any changes made on this application.
- ❐ Sign and date this application.

Important:

Please read the Agreement and Certification Section before signing this application.

Sanford®
Health Plan

PO Box 91110 • Sioux Falls, SD 57109-1110
(605) 333-1089 • 888-5-elite1 • 888-535-4831
www.sanfordhealthplan.com

Agent retain one copy • Member retain one copy • Send original to Health Plan

elite 1
An Individual Sanford Health Plan Product

☐ **New Policy**
☐ **Change to existing policy;**
Explain: ____________________

☐ **Requested effective date** ___/___/___
(If accepted, you will be billed from this date.)
☐ **Sanford Health Plan to assign effective date**
(First of the month following approval.)

1. Primary Applicant

First Name, M.I., Last Name	SSN/Copy of Permanent Green Card	Birth Date	Age	Gender	Height	Weight	Tobacco User
		___/___/___		☐ M ☐ F	___/___		☐ Y ☐ N

Are you a full-time college student? ☐ Yes ☐ No If yes, list college: ____________	Are you eligible for Medicare or disabled[3]? ☐ Yes ☐ No List Medicare #: ____________	Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced/Separated

Resident Street Address	City	State	Zip	County
Mailing Address (if different from above)	City	State	Zip	County

Home Phone	Work Phone	E-mail Address	Name of Employer	Best place and time to contact you: ☐ Home ☐ Work Time: ________

Family Physician	Clinic Name	City	State	Phone Number

2. Coverage Election

Coverage Option: ☐ Self ☐ Individual + One ☐ Family

Plan Option: ☐ $1,000 ☐ $1,500 ☐ $2,000* ☐ $2,500 ☐ $3,500* ☐ $5,000

Payment Option (check one): ☐ Monthly Automatic Account Withdrawal *(Must include an ACH form and **voided** check).*
☐ Quarterly Payment by Check *(Do not send payment with application)*

* includes maternity benefit

3. Dependent Information

First Name/M.I./Last Name	Relationship (Spouse/ Dependent)	Gender (M/F)	Birth Date (MM/DD/YY)	SSN/Permanent Green Card	If over 19, Full Time Student[1] (Y/N)	Height	Weight	Medicare eligible[2] or disabled[3]	Tobacco used during past 12 months?
						___/___		☐ Y ☐ N	☐ Y ☐ N
						___/___		☐ Y ☐ N	☐ Y ☐ N
						___/___		☐ Y ☐ N	☐ Y ☐ N
						___/___		☐ Y ☐ N	☐ Y ☐ N
						___/___		☐ Y ☐ N	☐ Y ☐ N
						___/___		☐ Y ☐ N	☐ Y ☐ N

[1]If dependent is over the age of 19, and a full time college student, please provide name of School/University, city and state.

____

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

____

[2]If yes, please list names and Medicare number if applicable ____________

[3]Is disabled person(s) eligible for Medicare? ☐ Yes ☐ No If Yes, please list names and Medicare number ____________

4. Previous Coverage

Indicate other health coverage for each person listed on this application. ***Please attach Certificate(s) of Creditable Coverage from your previous carrier(s).***

a. Are you currently or have you previously been enrolled with Sanford Health Plan? ☐ Yes, list ID# ____________ ☐ No
A written notice of cancellation must be received from the group health plan's employer HR representative before processing will commence.

b. Does any person named on this application have previous health care coverage of 12 months without a lapse of more than 63 days? ☐ Yes ☐ No
If yes, complete the following information to determine waiting period or coordination of benefits. If this section is not completed, an assumption will be made that there was no prior coverage and a 12-month pre-existing limitation may apply.

Applicant's Name	**Insurance Company Name, Policy # and Phone #**	**Dates of Coverage (MM/DD/YYYY)**		**Will this coverage continue? (Y/N)**	**Type of Policy**
		From	**To**		
					☐ Group ☐ Individual ☐ COBRA ☐ High Risk Pool
					☐ Group ☐ Individual ☐ COBRA ☐ High Risk Pool
					☐ Group ☐ Individual ☐ COBRA ☐ High Risk Pool

 Applicant initials ____________

5a. High Risk Health Assessment

Has any person listed on the application ever been recommended to have surgery or diagnostic testing for the following conditions or had any indications, signs, symptoms, diagnosis, treatment or advice by a doctor, chiropractor, psychologist, therapist, counselor or any health care professional or used any prescription or non-prescription medications for the following conditions? ☐ **Yes** ☐ **No**. If yes, check the box next to the condition(s) and complete Section 5d. *Health Statement*. A description of each of these conditions is listed at the end of this application. Furnish information about each condition listed or the application will be returned. **If an answer is changed, you, the applicant, must initial and date the change.**

☐ Addison's Disease	☐ Cystic Fibrosis	☐ Leukodystrophy	☐ Polycythemia Vera
☐ AIDS/HIV/ARC	☐ Diabetes Type I	☐ Marfan's Syndrome	☐ Psychosis Type: ______
☐ Alzheimer's/Dementia	☐ Dorsal Column Stimulators (use of)	☐ Mixed Connective Tissue Disease	☐ Scleroderma
☐ Amyotrophic Lateral Sclerosis (ALS)	☐ Down Syndrome	☐ Multiple Sclerosis	☐ Sjögren's Syndrome
☐ Anemia, Sickle Cell or Aplastic	☐ Emphysema/ Chronic Obstructive Pulmonary Disease (COPD)	☐ Muscular Dystrophy	☐ Spina Bifida
☐ Autism	☐ Fabry Disease	☐ Myasthenia Gravis	☐ Systemic Lupus Erythematosus
☐ Cancer (less than 5 years in remission) Type: ______	☐ Factor VIII or IX Deficiency	☐ Neurogenic Bladder	☐ Tabes Dorsalis
☐ Cerebral Palsy	☐ Fetal Alcohol Syndrome	☐ Organ Transplant Recipient (except Corneal)	☐ Tetrology of Fallot
☐ Chronic Atrial Fibrillation	☐ Fibromyalgia	☐ Paget's Disease	☐ Thalassemia Major
☐ Cirrhosis of the Liver	☐ Gardner Syndrome	☐ Paralysis	☐ Tourette's Disorder
☐ Congestive Heart Failure	☐ Gaucher Disease	☐ Parkinson's Disease	☐ Transient Ischemic Attack (TIA)
☐ Cor Pulmonale	☐ Hemophiliah	☐ Peripheral Vascular Disease	☐ Turners Syndrome
☐ Coronary Artery Disease	☐ Huntington's Chorea/Disease	☐ Pituitary Dwarfism	☐ Vagus Nerve Stimulators (any use of)
☐ Cushing's Syndrome	☐ Kidney Failure/Dialysis	☐ Polyaterisitis Nodosa	☐ Pregnant Due Date: ______

5b. Health Questionnaire (for detailed descriptions of conditions, see reverse side)

Has any person listed on the application ever been recommended to have surgery or diagnostic testing for the following conditions or had any indications, signs, symptoms, diagnosis, treatment or advice by a doctor, chiropractor, psychologist, therapist, counselor or any health care professional or used any prescription or non-prescription medications for the following conditions? Check the appropriate box next to each condition below. **If you answer "Yes" to any of these conditions, you must complete Section 5d, *Health Statement.***

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Abnormal Bleeding	☐	☐	Diabetes - Type 2 hbA1C Level: ______ Date Read: ______	☐	☐	Meningitis	☐	☐	Stomach Disorder	☐	☐
Allergies	☐	☐	Ear, Throat or Tonsil Disorders. Tubes in place?	☐	☐	Menstrual/Pelvic/Uterine Disorder	☐	☐	Stroke Date of Stroke: ___/___/___	☐	☐
Aortic Aneurysm	☐	☐	Eating disorders	☐	☐	Mental, Nervous or Emotional Disorder including depression or anxiety	☐	☐	Substance Abuse ☐ Alcoholism ☐ Drug	☐	☐
Arthritis Type: ______	☐	☐	Epilepsy/ Seizures	☐	☐	Migraines / Chronic Headaches	☐	☐	Surgery (within 3 years)	☐	☐
Asthma or Respiratory Disorders	☐	☐	Eye Disorder	☐	☐	Neurological Disorder	☐	☐	Thyroid Disorder-Type: ______	☐	☐
Atrial Fibrillation	☐	☐	Fracture Hardware ☐ Y ☐ N	☐	☐	Osteoporosis or Osteopenia	☐	☐	Tuberculosis/Positive TB Test	☐	☐
Attention Deficit Hyperactivity Disorder (ADHD/ADD)	☐	☐	Gallbladder Disorder	☐	☐	Pancreatic Disorders	☐	☐	Tumor(s) or growth	☐	☐
Back/Spinal Disorder	☐	☐	Gastric Bypass or Weight Loss Surgery	☐	☐	Pap Smear, Abnormal (See description)	☐	☐	Ulcerative Colitis, Crohn's Disease	☐	☐
Bladder Disorder	☐	☐	Gastric Reflux (GERD)	☐	☐	Polyps - Type: ______ Date removed: ___/___/___	☐	☐	Ulcers (Stomach or Duodenum)	☐	☐
Blood Disorder	☐	☐	Heart Disease	☐	☐	Prostate Disorder	☐	☐	Urinary Tract Disorder	☐	☐
Bone Disease/Deformity	☐	☐	Heart Murmur	☐	☐	Rectal Disorder	☐	☐	Varicose Veins	☐	☐
Bowel Disorder, Diverticulitis/Diverticulosis	☐	☐	Hernia - Type: ______	☐	☐	Reproductive Organ Disorder	☐	☐	Vein or Artery Disease	☐	☐
Breast Disorder	☐	☐	High Blood Pressure - Reading w/in past 6 mo: ____/____	☐	☐	Sarcoidosis	☐	☐			
Bronchitis	☐	☐	High Cholesterol - Current chol/HDL - Reading w/in past 6 mo. ____/____	☐	☐	Sexually Transmitted Disease, HPV, Genital Herpes, Syphilis	☐	☐			
Cancer (remission more than 5 years)	☐	☐	Joint Disorder	☐	☐	Sinus Disorder	☐	☐			
Cardiomyopathy	☐	☐	Kidney Disorder	☐	☐	Skin Cancer Type: ______	☐	☐			
Carpal Tunnel Syndrome	☐	☐	Liver Disorder/Hepatitis	☐	☐	Skin Disorder Type: ______	☐	☐			
Congenital Disease/Defects	☐	☐	Loss of Limb(s)	☐	☐	Sleep Apnea CPAP ☐ Y ☐ N	☐	☐			

 Applicant initials ______

5c. Additional Health Questions

1. Has an insurance company refused or restricted coverage for anyone listed on this application? ☐ Yes ☐ No Explain: ______
2. Do any applicants have any other condition or disease not mentioned above? ☐ Yes ☐ No Explain: ______
3. Are you or anyone listed on this application an expectant mother or father? ☐ Yes ☐ No Due Date: ______
4. Are you or anyone listed on this application experiencing any other undiagnosed symptoms? ☐ Yes ☐ No Explain: ______

5d. Health Statement

If you checked **"Yes"** to any of the health questions in Sections 5a or 5b, please complete this section. Use an **additional page** if needed.

Name	Name of Condition	Right / Left / Not Applicable	Date Diagnosed	Date Last Treated	Type of Treatment	Recovery Complete? (Y/N)	Physician Name / Specialty
						☐ Y ☐ N	
						☐ Y ☐ N	
						☐ Y ☐ N	
						☐ Y ☐ N	
						☐ Y ☐ N	
						☐ Y ☐ N	
						☐ Y ☐ N	

Additional pages attached? ☐ Yes ☐ No # of Pages ______

5e. Prescription Drug Questionnaire

List any drugs or injectable medications taken by all applicants within the past 12 months. Attach separate sheet if necessary.

Name	Medication Name	Dosage/ Frequency	Reason for Medication	Physician's Name / Specialty	Still Taking? (Y/N)
					☐ Y ☐ N
					☐ Y ☐ N
					☐ Y ☐ N
					☐ Y ☐ N
					☐ Y ☐ N
					☐ Y ☐ N
					☐ Y ☐ N

6. Signature

I have read and understand the Agreement and Certification language in this application and acknowledged receipt of a fully completed copy of this application and Summary of Payment for the health benefits, and how to access provider network information. I UNDERSTAND AND AGREE THAT THE HEALTH COVERAGE APPLIED FOR WILL NOT BE EFFECTIVE UNTIL SANFORD HEALTH PLAN, AS THE UNDERWRITER OF THE HEALTH COVERAGES, RESPECTIVELY, HAS REVIEWED AND APPROVED THIS APPLICATION AND NOTIFIED ME IN WRITING OF THE APPROVAL OF SUCH INSURER'S COVERAGE. SANFORD HEALTH PLAN UNDERWRITES COVERAGE UP TO THE EFFECTIVE DATE OF THE POLICY REGARDLESS OF WHEN THE APPLICATION WAS APPROVED. SHOULD YOU HAVE ANY CHANGE IN HEALTH STATUS PRIOR TO THE EFFECTIVE DATE, YOU MUST NOTIFY SANFORD HEALTH PLAN. Should my application not be approved, my payment (if any) will be refunded in full. I understand that any health condition rider or rate-up amendment(s) previously signed and/or in effect will remain under the new Sanford Health Plan policy elected.

Primary Applicant Signature Date Signed Spouse Signature Date Signed

Parent/Legal Guardian Signature (if applicant is under age 18) Print Name Relationship Date Signed

ALL AGENTS MUST COMPLETE AND SIGN:

The health questionnaire was completed by ☐ applicant ☐ agent

I certify that I have reviewed this application. If application was completed by agent, agent certifies that he/she personally completed this application, that each question was asked separately, that the answers recorded in this application are complete and accurate as given.

Agent Signature Print Name Agent # Date Signed

7. Tobacco Declaration

If anyone listed on this application used tobacco products (including cigarettes, cigars, pipes, chewing tobacco, nicotine products or any other form of tobacco) during the past 12 months. Tobacco rates will apply for a minimum of 12 months. If you answered no, you are eligible for a special non-tobacco rate. If this status changes, you must notify us immediately. We may require you to re-certify this status in the future. If we determine that this status is incorrect, we will retroactively collect historical differences in premiums before claims will be paid and will start applying the tobacco user rate.

8. Notice of Contractual Waiting Periods

I certify I have been informed of and understand that, if approved for enrollment into an individual Sanford Health Plan policy, the policy issued to me shall be subject to the following:

1. A 12-month waiting period for all medical conditions that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care or treatment during the 6 months immediately preceding the effective date of coverage and all medical conditions for which medical advice, diagnosis, care or treatment was recommended or received during the 6 months immediately preceding the effective date of this policy. The waiting period shall also apply to medications used to treat medical condition(s).
2. Coverage will not be provided for a pregnancy existing on the effective date of coverage.
3. There will be credit given toward satisfying the pre-existing waiting periods contained in the policy for which you have applied if you or any family member has had creditable coverage within the last 63 days. The other coverage must have provided substantially similar coverage. All pre-existing waiting periods contained in the policy applied for shall commence from the effective date of the policy as assigned by Sanford Health Plan.

There will be no credit given under this policy for any deductible or out-of-pocket maximum amounts incurred by you or members of your family under any other Sanford Health Plan policies or certificates or those of any other health insurance company. Only deductible and out-of-pocket maximum amounts incurred under the policy you are applying for will be applied toward satisfaction of the applicable deductible and out-of-pocket maximum amounts due under that policy.

9. Notice to Applicant Regarding Replacement of Accident and Sickness Insurance

If this coverage is intended to replace any health care coverage currently in force, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy or certificate if issued:

1. Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy or certificate. This could result in denial or delay of a claim for benefits under the new policy or certificate, whereas a similar claim might have been payable under your present policy.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your current policy. This is not only your right, but it is also in your best interest to ensure you understand all the relevant factors involved in replacing your present coverage.
3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical-health history. **Failure to include all vital medical information on an application may provide a basis for Sanford Health Plan to deny any future claims and to refund your premium as though your policy or certificate had never been in force.** After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

10. Agreement and Certification

I certify that I am legally authorized to apply for coverage for myself and all other persons named in this application. I understand that I am applying for coverage as indicated on this application which is underwritten by Sanford Health Plan providing the specified health care coverage. I further understand that coverage applied for will not start until after this application is accepted by Sanford Health Plan and the appropriate premium payment amount is received.

I certify that after this application was completed, I carefully and fully read it and that the statements and answers set forth are full, true, and correct to the best of my knowledge and belief, and no information required to be given, either expressly or by implication, has been knowingly withheld. I understand that Sanford Health Plan will rely on the completeness and truthfulness given in the statements made in this application, and that if I have made any false statements or misrepresentations, or have failed to disclose or have concealed any material fact, Sanford Health Plan will be entitled to declare coverage provided under this application void and to refuse allowance of benefits to any person hereunder.

If I am not required by Sanford Health Plan to answer health questions on this application, I understand that any health condition amendments previously signed and in effect on current individual coverage issued by Sanford Health Plan will remain in effect under this new coverage. I further agree, upon request, to furnish Sanford Health Plan all information required to administer the requested coverage.

Descriptions of Conditions

Abnormal Bleeding – Vaginal, rectal, or uterine bleeding, bleeding into a joint or muscle that causes pain and swelling, abnormal bleeding after an injury, easy bruising, frequent nosebleeds or blood in the urine.
Addison's Disease – Chronic adrenal insufficiency, or hypocortisolism.
AIDS/HIV – Acquired Immune Deficiency Syndrome or AIDS Related Complex (ARC) or positive HIV antibody test or positive HIV viruses.
Allergies – Any treatment for allergies (other than drug allergies) by shots, medication or oral drops.
Alzheimer's/Dementia – Progressive loss of mental skills such as memory, intelligence, judgment, language, and behavior.
Anemia, Sickle Cell or Aplastic – Genetic blood disease.
Amyotrophic Lateral Sclerosis (ALS) – Also known as Lou Gehrig's disease, a progressive wasting of certain nerve cells of the brain and spinal column.
Aortic Aneurysm – A bulging section in the wall of the aorta that is weakened and at risk of rupture.
Arthritis – Rheumatoid, degenerative or osteoarthritis, bursitis, tendonitis or juvenile.
Asthma, Respiratory Disorders – Treatment for asthma, including exercise induced asthma.
Atrial Fibrillation (chronic) – An abnormal irregular heart rhythm.
Attention Deficit Hyperactivity Disorder (ADHD) – A behavioral condition which causes difficulties paying attention and focusing on tasks, including ADD.
Autism – A brain disorder that interferes with a person's ability to communicate with and relate to others.
Back/Spinal Disorder – Any disorder of the back or spine including strains, sprains, injuries, abnormal curvature (scoliosis or kyphoscoliosis), intervertebral disc (slipped disc) fracture, kyphosis, herniated or bulging disc, stenosis, prior back or neck surgery, treatment by physical therapy, chiropractic care, massage therapy or other alternative therapies.
Bladder Disorder – Chronic or recurrent bladder infections, bladder stones, inability to control bladder, retention of urine.
Blood Disorder – Low blood count, abnormal bleeding from the skin, internal bleeding, leukemia, or Hodgkin's Disease.
Bone Disease/Deformity – Paget's Disease, exostosis, osteoporosis, bone tumors or deformity.
Bowel Disorder – Regional Enteritis, bleeding from the bowel, irritable bowel, diverticulosis or diverticulitis.
Breast Disorder – Breast masses, reconstruction, fibrocystic breast disease or any other breast disease.
Bronchitis – A respiratory disease in which the mucous membranes in the lungs become inflamed and swollen resulting in coughing, thick phlegm and shortness of breath reoccurring frequently for more than two years.
Cancer – Any type of cancer excluding skin cancer and melanoma.
Cardiomyopathy – A progressive heart muscle disease in which the heart is abnormally enlarged, thickened and/or stiffened.
Carpal Tunnel Syndrome – Any pain, tingling, numbness, weakness, in the fingers, thumb, hand, and arm.
Cerebral Palsy – A group of motor problems and physical disorders related to a brain injury that causes uncontrolled reflex movements and muscle spasticity.
Cirrhosis of the Liver – Inflammation of the liver caused by scar tissue.
Congenital Disease, Defects – All birth defects such as cleft lip or palate, fused fingers or other defects.
Congestive Heart Failure – Heart attack, a slowing of the blood through the heart and body resulting in an increase in blood pressure.
Cor Pulmonale – Enlargement of the right side of the heart.
Coronary Artery Disease – Coronary artery disease (CAD) is a narrowing of the small blood vessels that supply blood and oxygen to the heart. CAD is also called coronary heart disease.
Cushing's Syndrome – Also called hypercortisolism, a hormonal disorder caused by high levels of cortisol.
Cystic Fibrosis – A genetic disorder that affects mucus production.
Diabetes – Type I or II diabetes, insulin resistance, hypoglycemia, glucose intolerance, metabolic syndrome, syndrome X or any blood sugars under observation or being managed by diet and or medication.

Dorsal Column Stimulators – A device used to treat severe low back and lower extremity pain.
Down Syndrome – A chromosome disorder due to an extra chromosome number 21 (Trisomy 21) that causes mental retardation and multiple malformations.
Ear, Throat, Tonsil Disorder – Treated deafness, tubes in ears, chronic ear infections, chronic sore throat, enlarged tonsils or adenoids, vocal cord nodules.
Eating Disorders – Anorexia, bulimia, binge eating or any disorder characterized by disturbances in eating behavior.
Emphysema/Chronic Obstructive Pulmonary Disease (COPD) – Any treatment for or diagnosis of emphysema or COPD, a group of long-term lung diseases that blocks the airflow to and within the lungs.
Epilepsy and/or Seizure Disorder – Any history of seizures.
Eye Disorder – Any disease that impairs eyes including but not limited to glaucoma or cataracts. Glaucoma is a disease that causes loss of eye sight. A cataract is a clouding of the lens of the eye that can impair vision.
Fabry Disease – A rare genetic disorder of lipid metabolism that causes abnormal accumulation of fatty material in various organs of the body, particularly blood vessels and the eyes.
Factor VIII or IX Deficiency – Key factors in the process of blood clotting. Lack of normal factor VIII causes hemophilia A and lack of factor IX causes Hemophilia B.
Fetal Alcohol Syndrome – Severe birth defects caused by alcohol use during pregnancy. Characterized by abnormal facial features, central nervous system, behavioral and growth problems.
Fibromyalgia – Pain in the muscles, soft tissues, back, or neck and certain tender points on the body.
Fracture – If ever present. Hardware: Includes pins, caps, artificial joints, etc.
Gallbladder Disorder – Treatment of gallstones, removal of gallstones or gallbladder, or gallbladder attack.
Gardner Syndrome – A type of familial adenomatous polyposis (FAP), a genetic disease characterized by gastrointestinal polyps, bone, skin and soft tissue tumors.
Gastric Bypass/Weight Loss Surgery – Surgery on the stomach and/or intestines to assist with weight loss.
Gastric Reflux (GERD) – The abnormal backflow, or reflux, of stomach acid and juices into the esophagus.
Gaucher Disease –A chronic, progressive, inherited genetic disorder resulting in lack of sufficient levels of a particular enzyme.
Heart Disease – Any disease of the heart that has been diagnosed or treated, such as heart attack, coronary artery disease, abnormal rhythm, birth defect, or infections, mitral valve prolapse.
Heart Murmur – An extra sound that the blood makes as it flows through the heart.
Hemophilia – Inherited bleeding disorders in which the ability of blood to clot is impaired.
Hernia – Inguinal, ventral, incisional, or hiatal hernia.
High Blood Pressure – Any elevation of blood pressure, either presently being treated by medication or diet or treated in the past.
High Cholesterol – A cholesterol build up in arteries that can block blood flow to the heart or brain and cause a heart attack or stroke.
Huntington's Chorea/Disease – Degeneration of the brain that causes muscle spasticity, dementia and loss of mental abilities.
Joint Disorder – Treatment or surgery for any joint disorder including exploratory surgery or joint fusion. Including but not limited to hip, knee, shoulder, elbow and wrist.
Kidney Disorder – Kidney stones, enlarged, misplaced, injured kidney, chronic infection or nephritis.
Kidney Failure/Dialysis – Failure of the kidneys to filter waste and balance water, salt, and mineral (electrolyte) levels in the blood, treated by kidney dialysis, an artificial means of filtering the bloodstream.
Leukodystrophy – Degeneration of the brain that causes progressive loss in body tone, movements, gait, speech, ability to eat, vision, hearing, and behavior.
Liver Disorder/Hepatitis – Any disease or inflammation of the liver.
Loss of Limb(s) – Any loss of limb (legs, arms, fingers, toes) or use of prosthetic device.
Marfan's Syndrome – An inherited disorder of connective tissue characterized by abnormalities of the eyes, skeleton and cardiovascular system.
Meningitis – Diagnosis or treatment for viral or bacterial spinal meningitis.
Menstrual/Pelvic/Uterine Disorder – Irregular periods, excessive bleeding, missed periods, miscarriages, endometriosis, hysterectomy, ovarian or fibroid cysts, and pelvic inflammatory disease.
Mental, Nervous, Emotional Disorder – Any disorder treated by a psychologist, physician or counselor that results in a disruption of a person's thinking, feeling, moods, and ability to relate to others including depression & anxiety.
Migraines/Chronic Headaches – Cluster headaches, or chronic tension headaches.
Mixed Connective Tissue Disease – A mixture of three connective tissue diseases including systemic lupus erythematosus, scleroderma, and polymyositis.
Multiple Sclerosis – Chronic central nervous system disease that affects muscle control and strength, vision, balance, sensation, and mental functions.
Muscular Dystrophy – Disease of the nerves and muscles that cause rapid wasting and progressive weakness.
Myasthenia Gravis – Disease that causes muscles to tire and weaken easily.
Neurogenic Bladder – Loss of normal bladder function.
Neurological Disorder – Any brain disorder such as abnormal growth in the brain (tumor) or hydrocephaly (water on the brain).
Organ Transplant Recipient – Replacement or donation of an organ other than cornea.
Osteoporosis or Osteopenia – Thinning of the bones with reduction in bone mass due to depletion of calcium and bone protein.
Paget's Disease – Abnormal bone growth that results in brittle bones, bone pain, or deformed bones.
Pancreatic Disorders – Acute or chronic pancreatitis or pancreatic cysts.
Pap Smear, Abnormal (within 2 years) – Diagnosis or treatment cervical dysplasia, abnormal Pap.
Paralysis – Any loss of movement of a muscle or limb including Hemiplegia, Agitans, Apoplectic, Paraplegia, Progressive, Spastic or Quadriplegic.
Parkinson's Disease – Chronic neurological condition, if ever present.
Peripheral Vascular Disease – A disease of the arteries caused by build up of fatty material within the vessels.
Pituitary Dwarfism – Condition of growth retardation that results in very short, but normal body proportions.
Polyaterisitis Nodosa – A serious blood vessel disease in which arteries become swollen and damaged affecting the skin, heart, kidneys, and nervous system.
Polycythemia Vera – An abnormal increase in blood cells (primarily red blood cells) resulting from excess production by the bone marrow.
Polyps – A mass of tissue growth that develops on the inside wall of a hollow organ including colon, colorectal, cervical, or nasal.
Pregnant – Confirmed or suspected pregnancy; includes positive home pregnancy test or missing more than one period or presence of all or most of the symptoms of pregnancy, whether the pregnancy has been confirmed by a physician or not.
Prostate Disorder – Infection or enlargement of prostate.
Psychosis – A mental illness which grossly impairs a person's sense of reality including but not limited to bipolar, delusional, dementia, schizophrenia and schizo-affective disorder.
Rectal Disorder – Rectal bleeding, hemorrhoids, fissure, fistula, polyps, anal warts.
Reproductive Organ Disorder – Any disorder of the female or male reproductive organs including history of gender reassignment surgery, testicular disorders, congenital disorders.
Sarcoidosis – An inflammatory disease of organs in the body, but mostly the lungs and lymph glands that causes abnormal masses or nodules.
Scleroderma – A connective tissue disease with the formation of scar tissue (fibrosis) in the skin and/or other organs.
Sexually Transmitted Diseases – Treatment for genital herpes, HPV, gonorrhea, Chlamydia, CMV, syphilis or any venereal disease.
Sinus Disorder – Any treatment for sinus problems including multiple sinus infections, inflammation, polyps, cysts, previous sinus surgery or nasal breathing problems.
Sjögren's Syndrome – An autoimmune disease that causes dry eyes, dry mouth, and other connective tissue diseases such as rheumatoid arthritis, lupus, scleroderma or polymyositis.
Skin Cancer – Any type including basal, squamous or melanoma.
Skin Disorder – Diagnosis or treatment for any skin disease including acne, psoriasis, chronic contact dermatitis, eczema, skin pigmentation disorders, birth marks, hemangioma, karatosis, shingles, ulcers, nail disorders, cysts, and tumors.
Sleep Apnea – The temporary stoppage of breathing during sleep, often resulting in daytime sleepiness, including the use of CPAP.
Spina Bifida – A birth defect in which the bones of the spine do not form properly around the spinal cord.
Stomach Disorder – Any condition of the stomach or esophagus such as ulcer, stricture, gastritis, esophageal reflux, or hyperacidity.
Stroke – The sudden death of some brain cells due to a lack of oxygen caused by a blockage or rupture of an artery to the brain.
Substance Abuse – Drug: Any use of psychoactive substances including recreational or illegal drugs. Alcoholism: Treatment or counseling for alcohol abuse by health care provider, clergy, social worker, AA organization or others.
Surgery (within 3 years) – If ever present.
Systemic Lupus Erythematosus – A chronic inflammatory condition caused by an autoimmune disease in which the immune system attacks an organ.
Tabes Dorsalis – Slowly progressive degeneration of the spinal cord that occurs in the third phase of syphilis.
Tetralogy of Fallot – A heart defect in children.
Thalassemia Major – Genetic blood disorder, hemolytic anemia
Thyroid Disorder – Enlargement of the thyroid, removal of nodule or lumps. hyperthyroidism (overactive), hypothyroidism (underactive), Grave019}s Disease.
Tourette's Disorder – Neurological disorder that results in uncontrollable sounds or words (vocal tics) and body movements (motor tics).
Transient Ischemic Attack (TIA) – A mini-stroke; when blood flow to part of the brain is temporarily blocked by a blood clot.
Tuberculosis/Positive TB Test – Any history or treatment of tuberculosis.
Tumor(s) or Growth – Any type of lump, tumor or growth, (cancerous or benign).
Turners Syndrome – Chromosomal disorder of females characterized by short stature and the lack of sexual development at puberty.
Ulcerative Colitis – An inflammatory bowel disease that causes inflammation and sores (ulcers) in the lining of the large intestine; Crohn's disease, Diverticulosis, Diverticulitis.
Ulcers – A sore in the inner lining of the stomach or upper small intestine (duodenum).
Urinary Tract Disorder – Chronic or recurrent urinary tract infection, stricture of urinary tract, urethral stones or any condition of the urinary tract.
Vagus Nerve Stimulators – A device used to treat epilepsy and depression.
Varicose Veins – History of vein stripping or varicose veins requiring medical treatment.
Vein or Artery Disease – Any disease or accidental injury that has caused obstruction of a blood vessel to a body part; hardening of the arteries (arteriosclerosis), aneurysm, blood clots (superficial or deep vein thrombosis), thrombophlebitis, embolism, narrowing of the blood vessel (stenosis), poor circulation, AVM, hemangiom.

 Applicant initials ______________

HIPAA AUTHORIZATION FORM FOR PRE-ENROLLMENT USES AND DISCLOSURES OF MEMBER INFORMATION

Plan Type: ☐ Employer Group ☐ Medicare Supplement/SELECT ☐ elite1 Individual

Applican Type: ☐ New Applicant ☐ Existing Sanford Health Plan Member

I hereby authorize the use or disclosure of personal health information about me as described below.

1. I authorize Sanford Health Plan to use the personal health information I have provided on the application form to determine my eligibility to obtain coverage under the health benefits plan, for which I have applied, and to determine the rates and terms which apply to the plan/policy.
2. I also authorize all health care providers and pharmacy benefit managers who have provided treatment or other health care services to me to disclose all information regarding my treatment to Sanford Health Plan.
3. The following group of persons employed or working for Sanford Health Plan may use my personal health information which is described above: employees of the Underwriting and Member Services departments.
4. The information which is disclosed by health care providers described above may be used by Sanford Health Plan to determine my eligibility to obtain coverage under the health benefits plan, for which I have applied, and to determine the rates and terms which apply to the plan/policy.
5. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by Sanford Health Plan in reliance on this authorization, by sending a written revocation to Sanford Health Plan, Attn: Member Services, PO Box 91110, Sioux Falls, SD 57109-1110.
6. This authorization will expire when Sanford Health Plan has approved or denied my application to enroll in the health benefits plan.
7. I understand that the information which will be provided under this authorization is necessary for Sanford Health Plan to determine my eligibility for coverage under the health benefits plan and that Sanford Health Plan will condition enrollment in the health benefits plan/policy on my providing this authorization, and my application may be denied if I refuse to provide this authorization.
8. I understand that if the person or entity that receives my personal health information is a not a health care provider or health plan covered by the federal privacy regulations, the information may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations. In the case of this authorization, however, the information described above will be received by a health plan which is covered by the federal privacy regulations, and will not be used or redisclosed except as described above, and the information will continue to be protected under the federal privacy regulations

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Applicant Name (or Legal Representative[1]) Signature Date Social Security Number

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Spouse Name Signature Date Social Security Number

Dependent Name Signature[2] (if age 18 and over) Social Security Number

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Dependent Name Signature[2] (if age 18 and over) Social Security Number

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Dependent Name Signature[2] (if age 18 and over) Social Security Number

[1] *If you are the legal representative of the applicant and are not the parent of a minor, you must attach evidence of your authority to act as the applicant's representative for this authorization to be valid (i.e. Power of Attorney)*

[2] *If under the age of 18. The parent or guardian must sign on the child's behalf and indicate their relationship next to their signature.*

Please attach the white copy to your enrollment application.

White copy: Health Plan Yellow copy: Human Resources Pink copy: Applicant

PO Box 91110
Sioux Falls, SD 57109-1110
(605) 328-6868
(877) 305-5463

PRE-ARRANGED PAYMENT AUTHORIZATION

Plan Type: ☐ elite1 ☐ Medicare Supplement/SELECT
Applicant Type: ☐ New Applicant ☐ Existing Plan Member

IMPORTANT: Please complete and sign this form in order to have your monthly premiums automatically deducted from your checking account. Mail this form along with a **voided check** at the above address. Please keep a copy for your records.
It takes approximately two weeks to establish monthly automatic account withdrawal. If your next premium is due during the two-week processing period, automatic deduction will NOT be in force and **2 months premiums will be deducted the following month**. Deductions are taken on or around the 10th of each month. A record of each automatic withdrawal will appear on your regular bank statement.

Policy Holder Name	Social Security Number	Health Plan ID Card Number (if you are a current Member)

I hereby authorize Sanford Health Plan to initiate debit entries to my checking account indicated below, and the bank named below, to debit the same to such account. **I have included a voided check from the account I want debited.**

Bank Name	Branch	Depository (Routing) Number	Account Number
Bank Address			
City		State	Zip Code

On (today's date) ____/____/____ I authorize Sanford Health Plan, mailing address PO Box 91110, Sioux Falls, SD 57109-1110, to initiate electronic entries to my checking/savings account and agree to the terms listed on this authorization form for payment of ___________________________________(indicate insurance plan name/type).

To cancel your automatic account withdrawals please notify us in writing at the above address at least 20 days prior to your next scheduled withdrawal.

This authorization is to remain effective until the Sanford Health Plan and the Bank have received **written notification** from me of its termination in such time and in such a manner as to afford Sanford Health Plan and the Bank a reasonable opportunity to act on it. I authorize Sanford Health Plan to change the amount of the debit provided **written notice** of such change is given in such a time as to afford me a reasonable opportunity to act on it.

Account Holder Signature	Date

 White Copy: Health Plan *Pink Copy: Applicant*