SHARP HEALTH PLAN

Special Enrollment Period

Health Insurance Application

Purpose

The purpose of this form is to help you apply for health insurance during Special Enrollment. Filling out this form means you are applying for an individual or family plan — within 60 days of a qualifying event — with Sharp Health Plan.

Instructions

Fill out this form if you would like to make changes to your benefit plan, or update the personal information associated with your account.

You can make changes to the following:

- Your Subscriber Information
- Your Coverage
- Your Benefit Plan and Network

Covered California Members: To add a dependent or change your benefit plan, please contact Covered CA at 1-800-300-1506. You can also change or update your account online by logging in to your Covered CA account at **coveredca.com**.

Submit

Please submit the finished form by mail, in person*, or fax:

By Mail or In Person*:
Sharp Health Plan
Attention: IFP Sales
8520 Tech Way, Suite 200
San Diego, CA 92123

By Fax:
Attention: IFP Sales
(858) 499-8246

*Pending safety guidelines

If you need assistance, we're here to help.

You can call Customer Care at (858) 499-8300 or toll-free at 1-800-359-2002.
We are available to assist you Monday through Friday, 8 a.m. to 6 p.m.

Make a Payment

To pay your premium with your debit or credit card, please visit **sharphealthplan.com/payment**, or mail your check or money order to:

Sharp Health Plan
P.O. Box 57248
Los Angeles, CA 90074-7248

If you need assistance, we're here to help.
You can call our IFP Sales Team at 1-858-499-8211 or email us at IFPSales@sharp.com.
We are available to assist you Monday through Friday, 8 a.m. to 5 p.m.

Preliminary Information

Are you currently enrolled in a Sharp Health Plan Individual or Family Plan? ◯ Yes ◯ No

If yes, please enter your subscriber identifier number (provided on renewal letter):

Are you making any changes to your current policy? ☐ Yes — Changes to plan design ☐ Yes — Add dependents

Step 1a. Subscriber Information (policy holder) Please print.

First name: Middle initial: Last name:

Birth date: MM/DD/YY / /	Social Security number: – –	Marital status: ◉ Single ○ Married ○ Widowed ○ State registered domestic partner ○ Child only application	Sex: ○ M ○ F

Home address (P.O. Box is not allowed):

City:	State:	ZIP code:

Billing address (if different from above):

City:	State:	ZIP code:

Best phone number to reach you: ○ Home ○ Cell ○ Work ( )	Other phone number: ○ Home ○ Cell ○ Work ( )

Email address:

Are you willing to receive information from Sharp Health Plan by email and/or text? For text, message or data rates may apply. ○ Yes ○ No

Please note any communication assistance or special needs:

Preferred spoken or written language (if not English):

To find a Sharp Health Plan-affiliated doctor who meets your needs, and their provider ID, please visit **sharphealthplan.com** and select "Find a doctor," or call Customer Care at 1-800-359-2002.

Primary care physician (If left blank, Sharp Health Plan will assign a PCP.):		Are you an existing patient with this doctor? ○ Yes ○ No
Name:	Provider NPI:	

Pediatric Dental

Please note applicants under age 19 will automatically be enrolled in a pediatric dental plan with Delta Dental of California. To find a Delta Dental dentist in your network, visit deltadentalins.com/group_sites/deltacare-usa-groups/, use the "Find a Dentist" dentist look-up and choose a dentist in the DeltaCare USA Network. You must use a dentist in the DeltaCare USA network to be eligible for dental benefits.

DeltaCare USA is underwritten in these states by these entities: AL — Alpha Dental of Alabama, Inc.; AZ — Alpha Dental of Arizona, Inc.; CA — Delta Dental of California; CO, MA, MI, NC, OK, OR, WA — Dentegra Insurance Company; CT, DC, DE, FL, GA, LA, MS, TN — Delta Dental Insurance Company; ID, KY, MD, MO, NJ, OH, TX — Alpha Dental Programs, Inc.; UT — Alpha Dental of Utah, Inc.; NY — Delta Dental of New York, Inc.; PA — Delta Dental of Pennsylvania. Delta Dental Insurance Company acts as the DeltaCare USA administrator in all these states. These companies are financially responsible for their own products.

Pediatric Vision

Please note applicants under age 19 will automatically be enrolled on a pediatric vision plan. Services are provided by Vision Service Plan (VSP). To search a list of available eye doctors, go to **vsp.com/advantage**.

Step 1b. Parent or Legal Guardian (if the subscriber applicant is a child under 18)

First name: Middle initial: Last name:

Birth date: MM/DD/YY / /

Social Security number: – –

Best phone number: ◯ Home ◯ Cell ◯ Work ( )

Sex: ◯ M ◯ F

Home address (P.O. Box is not allowed):

City: State: ZIP code:

Step 1c. Spouse or Domestic Partner

Complete the following information if you wish to add a spouse / domestic partner to this policy. Otherwise, skip to Step 2.

First name: Middle initial: Last name:

Birth date: MM/DD/YY / /

Social Security number: – –

Relationship to subscriber: ◯ Spouse ◯ State registered domestic partner

Sex: ◯ M ◯ F

To find a Sharp Health Plan-affiliated doctor who meets your needs, and their Provider NPI, please visit **sharphealthplan.com** and select "Find a doctor," or call Customer Care at 1-800-359-2002.

Primary care physician (If left blank, Sharp Health Plan will assign a PCP.):

Name: Provider NPI:

Are you an existing patient with this doctor? ◯ Yes ◯ No

Step 1d. Dependents

Complete the following information for each dependent you wish to add to this policy. Otherwise, skip to Step 2.

1. First name: Middle initial: Last name:

Birth date: MM/DD/YY / /

Social Security number: – –

Relationship to subscriber:

Sex: ◯ M ◯ F

To find a Sharp Health Plan-affiliated doctor who meets your needs, and their provider ID, please visit **sharphealthplan.com** and select "Find a doctor," or call Customer Care at 1-800-359-2002.

Primary care physician (If left blank, Sharp Health Plan will assign a PCP.):

Name: Provider NPI:

Are you an existing patient with this doctor? ◯ Yes ◯ No

2. First name: Middle initial: Last name:

Birth date: MM/DD/YY / /

Social Security number: – –

Relationship to subscriber:

Sex: ◯ M ◯ F

To find a Sharp Health Plan-affiliated doctor who meets your needs, and their provider ID, please visit **sharphealthplan.com** and select "Find a doctor," or call Customer Care at 1-800-359-2002.

Primary care physician (If left blank, Sharp Health Plan will assign a PCP.):

Name: Provider NPI:

Are you an existing patient with this doctor? ◯ Yes ◯ No

3. First name:	Middle initial:	Last name:	
Birth date: MM/DD/YY / /	Social Security number: – –	Relationship to subscriber:	Sex: ◯M ◯F

To find a Sharp Health Plan-affiliated doctor who meets your needs, and their provider ID, please visit **sharphealthplan.com** and select "Find a doctor," or call Customer Care at 1-800-359-2002.

Primary care physician (If left blank, Sharp Health Plan will assign a PCP.):		Are you an existing patient with this doctor? ◯Yes ◯No
Name:	Provider NPI:	

Step 2. Plan Selection

When selecting a plan, you must ensure that you either live or work in a ZIP code that is within that plan's network. Go to **sharphealthplan.com/networks-by-zip** to see which ZIP codes are included in each plan network. Once you have confirmed your network, you must then select one benefit plan from the list below.

Premier Network	
Plan Name	**Metal Tier**
☐ Sharp Platinum 90 Premier HMO	Platinum
☐ Sharp Gold 80 Premier HMO	Gold
☐ Sharp Silver 70 Off Exchange Premier HMO	Silver
☐ Sharp Bronze 60 HDHP Premier HMO	Bronze

Performance Network	
Plan Name	**Metal Tier**
☐ Sharp Platinum 90 Performance HMO	Platinum
☐ Sharp Gold 80 Performance HMO	Gold
☐ Sharp Silver 70 Off Exchange Performance HMO	Silver
☐ Sharp Bronze 60 Performance HMO	Bronze
☐ Sharp Minimum Coverage Performance HMO*	Minimum Coverage

Verification of residency is required for all applicants.
This application requires a verification of residency for the subscriber. If the applicant is a minor applying for coverage as a subscriber, the parent(s) or legal guardian(s) must provide proof of residency. In the case of surrogacy, the residence of the legal guardian is required. Surrogate mother proof of residency is not required. The proof of residency must be received within 10 business days of the receipt of the application (completed in its entirety), and entails the following: One item from List 1 and another item from either List 1 or List 2 must be provided. Both documents must show residency in a ZIP code for the Sharp Health Plan service area of the product selected. If Sharp Health Plan does not receive proof of residency documents for the subscriber within 10 business days of receipt of the completed application, Sharp Health Plan will cancel this application.

List 1	**List 2**
• Gas, electricity, water, or cable billing statement (recent). If your qualification was for a permanent move, the billing statement must be for initial service. • Valid California driver's license or California photo ID card. If your qualification was for a permanent move, the ID must be recently issued. • Employment paycheck stub (recent). If your qualification was for a permanent move, the paycheck stub must include the year-to-date pay confirming new employment.	• California DMV history printout • California income tax return filing (540) • California state aid or assistance program documentation • California motor vehicle registration or motor vehicle insurance • Military discharge papers (DD214) or Leave and Earnings statement • Home property tax statement • School transcripts, school registration, school ID, or school housing contract (for applicants under age 18 applying as the subscriber

Additionally, each plan has a designated group of physicians and hospitals associated with it, known as a plan medical group (PMG). The plan you select will determine the doctors that are available to you. To find a Sharp Health Plan-affiliated doctor who meets your needs, please visit **sharphealthplan.com** and select "Find a doctor" to find a doctor near you, or call Customer Care at 1-800-359-2002. Please be sure to select a doctor that is affiliated with the plan network for the benefit plan you would like to enroll in. **If you leave the primary care physician (PCP) field blank in Step 1, then Sharp Health Plan will assign a PCP to you automatically.**

* Minimum coverage plans are available to individuals under the age of 30, as of the effective date of coverage. They are also available to those that have received a certificate of exemption from Covered California due to affordability or hardship. If an applicant is 30 years of age or older, the certificate of exemption must be provided to Sharp Health Plan in order to process the application.

Effective Date of Coverage

What is the requested effective date of your medical policy? _____

Qualifying Event for Applying Outside of the Open Enrollment Period

Request for enrollment must be submitted within 60 days of a qualifying event. Attach proof of qualifying event to application.

All required supporting documentation and your first month's premium payment must be submitted to the Plan before your coverage effective date.

- ☐ Loss of coverage
- ☐ Marriage
- ☐ Birth / Adoption
- ☐ Divorce
- ☐ Other _____

Your coverage starts on your effective date

Your effective date will depend on the kind of qualifying event you have.

Still unsure how it works? Here's an example:
Ron lost his Minimum Essential Coverage on March 31. After looking at his options for health insurance, Ron sent his complete special enrollment application to Sharp Health Plan on April 11. In order for Ron's new health coverage to start on May 1, Sharp Health Plan must receive Ron's required documentation and first payment no later than April 30.

Use the chart below to see which effective date applies to your situation.

My qualifying event involves…	If I apply…	My coverage will start on…
Birth, adoption, placement for adoption or foster care	Any day of the month	Date of birth, adoption, placement for adoption, foster care, OR the 1st day of the month after your qualifying event if you request a later effective date
Marriage or domestic partnership registration	Any day of the month	The 1st of the month after we receive your application or Account Change Form
Child support order or other court order to cover a dependent	Any day of the month	Date the court order is effective
Loss of health care coverage	On or before your last day of coverage	The 1st of the month, after your last day of coverage
Change in eligibility for employer coverage	Any day of the month	The 1st of the month after we receive your application or Account Change Form
Loss of minimum essential coverage due to the death of the subscriber	Any day of the month	The 1st of the month after we receive your application or Account Change Form
Divorce, legal separation or dissolution of domestic partnership	Any day of the month	The 1st of the month after we receive your application or Account Change Form
Termination of non-calendar year plan	Any day of the month	The 1st of the month after we receive your application
All other qualifying events	Between the 1st and the 15th day of the month	The 1st of the following month
	Between the 1st and the 15th day of the month	The 1st of the second following month

Step 3. Broker / Agent / Staff member

Did you work with a Broker / Agent / Staff member? ◯ Yes ◯ No

If an agent, broker or Sharp Health Plan staff member helped you with this application, please make sure he or she completes this section. Otherwise, skip to Step 4.

Broker / Agent / Staff member name:	Agency name:	License number:

Notice to Broker / Agent / Staff member: If you have assisted the applicant in submitting this application, the law requires that you attest to this assistance. If you state any material fact you know to be false, you are subject to a civil penalty of up to ten thousand dollars ($10,000), as authorized under Federal Government and Safety Code section 1389.8(c) or Insurance Code section 10119.3.

Select one:

☐ I assisted the applicant in submitting this application. To the best of my knowledge, the information on this application is complete and accurate. I explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information, and the applicant understood the explanation.

☐ I did not assist the applicant in any way in completing or submitted this application. All information was completed by the applicant with no assistance or advice from me.

Broker / Agent / Staff member signature:	Date:
x	

Step 4. Disclosures and Signatures

Please read the following carefully. Each applying family member age 18 and older is required to review the completed application and provide their own signature on the following page. Keep a copy of this application for your records.

Dental Disclosures

I understand that if I have indicated that coverage under the Plan is to be provided only for the dependent child on this form, I am responsible for payment of the required Premium and compliance with all of the provisions and conditions of the Disclosure Form / Contract.

RIGHT OF REIMBURSEMENT: I, on my behalf of my Dependent(s) listed on this Enrollment Application, hereby agree that in the event any dental services provided to me or my Dependent(s) covered by Delta Dental of California are the primary financial responsibility of another party because of other dental coverage, I will fully inform Delta Dental of California and will execute such assignments, liens or other documents which may be necessary to enable Delta Dental of California to recover the value of services and supplies provided.

NOTICE: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud and may be subject to fines and confinement in prison.

(continued on next page)

Step 4, continued

Sharp Health Plan Disclosures

- I alone am responsible for the accuracy and completeness of the information provided on this application. I have personally reviewed all information provided on this application, even if I did not fill out the application myself. To the best of my knowledge and belief, all information on this application is accurate, true and complete. If Sharp Health Plan determines that there is fraud (by act, practice or omission) or an intentional misrepresentation of material fact in the information on this application, I understand that coverage may be rescinded as allowed by law.
- Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud and may be subject to fines and confinement in prison.
- In accordance with the disclosure requirements of California Health & Safety Code, Section 1363 (h), this is to advise you that Sharp Health Plans' ratio of health care expenses to premiums received for the last fiscal year with respect to the Sharp Health Plan Individual & Family Plans was 84.3%.
- I understand that I may be subject to an audit by Sharp Health Plan, at which time I will need to provide proof of residency, date of birth and dependent eligibility (if applicable). I further understand that I must provide Sharp Health Plan with any new information that arises after the submission of this application but before my enrollment with Sharp Health Plan begins.
- I understand that this plan will only cover services provided through my plan's network of providers and facilities, unless I receive prior written authorization from Sharp Health Plan, or unless the services are emergency care services or out-of-area urgent care.
- If I indicated in Step 1 that I have a language preference other than English and have completed the English version of this application (or version other than in my language preference), I confirm that I understand the questions on this application.
- I understand that California law prohibits an HIV test from being required or used by health care plans as a condition of obtaining coverage.
- Depending on income level and family size, I understand that I may be eligible for financial assistance to help pay for health coverage if I purchase my coverage through Covered California. Sharp Health Plan benefit plans are available through Covered California. I must apply during an open or special enrollment period. Open enrollment is from Nov. 1 through Jan. 31. However, I understand that in order for coverage to begin on Jan. 1, I must submit my application on or before Dec. 15 of the preceding calendar year. If I have a life change such as marriage, divorce, a new child or loss of a job, I can apply at the time the life change occurs ("special enrollment period").
- I understand that I have the right to use Sharp Health Plan's internal dispute resolution process if any dispute or controversy arises regarding the performance, interpretation, or breach of the agreement between myself (and/or enrolled dependent) and Sharp Health Plan, whether in contract, tort, or otherwise. If I am unsatisfied with the result of the dispute resolution process, I understand that I have the right to voluntary binding arbitration, which is the final step for resolving complaints. Upon receipt of a demand for arbitration, Sharp Health Plan agrees to utilize a neutral arbiter from an appropriate entity. Arbitration will be conducted in accordance with the rules and regulations of the chosen entity.

Subscriber (parent or legal guardian for subscriber if under 18)		
Name:	Signature: **x**	Date:
Spouse / Domestic Partner (if applicable)		
Name:	Signature: **x**	Date:
Dependent 1 (over 18) (if applicable)		
Name:	Signature: **x**	Date:
Dependent 2 (over 18) (if applicable)		
Name:	Signature: **x**	Date:
Dependent 3 (over 18) (if applicable)		
Name:	Signature: **x**	Date:

Nondiscrimination Notice

Sharp Health Plan complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability. Sharp Health Plan does not exclude people or treat them differently because of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability.

Sharp Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Information in other formats (such as large print, audio, accessible electronic formats or other formats) free of charge
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Customer Care at 1-800-359-2002.

If you believe that Sharp Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability, you can file a grievance with our Civil Rights Coordinator at:

- Address: Sharp Health Plan Appeal/Grievance Department, 8520 Tech Way, Suite 200, San Diego, CA 92123-1450
- Telephone: 1-800-359-2002 (TTY 711) Fax: 1-619-740-8572

You can file a grievance in person or by mail or fax, or you can also complete the online Grievance / Appeal form on the plan's website **sharphealthplan.com**. Please call our Customer Care team at 1-800-359-2002 if you need help filing a grievance. You can also file a discrimination complaint if there is a concern of discrimination based on race, color, national origin, age, disability or sex with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD).

Complaint forms are available at **hhs.gov/ocr/office/file/index.html**.

The California Department of Managed Health Care is responsible for regulating health care service plans. If your grievance has not been satisfactorily resolved by Sharp Health Plan or your grievance has remained unresolved for more than 30 days, you may call toll-free the Department of Managed Health Care for assistance:

- 1-888-466-2219 Voice
- 1-877-688-9891 TDD

The Department of Managed Health Care's website has complaint forms and instructions online: **www.dmhc.ca.gov**

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call Sharp Health Plan right away at 1-858-499-8300 or 1-800-359-2002.

IMPORTANTE: ¿Puede leer esta carta? Si no le es posible, podemos ofrecerle ayuda para que alguien se la lea. Además, usted también puede obtener esta carta en su idioma. Para ayuda gratuita, por favor llame a Sharp Health Plan inmediatamente al 1-858-499-8300 o 1-800-359-2002.

Language Assistance Services

English:
ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-800-359-2002 (TTY:711).

Español (Spanish):
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-359-2002 (TTY:711).

繁體中文 (Chinese):
注意 ： 如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-359-2002 (TTY:711)。

Tiếng Việt (Vietnamese):
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-359-2002 (TTY:711).

Tagalog (Tagalog – Filipino):
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-359-2002 (TTY:711).

한국어 **(Korean):**
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-359-2002 (TTY:711) 번으로 전화해 주십시오.

Հայերեն **(Armenian):**
ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-800-359-2002 (TTY (հեռատիպ)՝ 711).

(Farsi): فارسی

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما
فراهم می باشد. با (TTY:711) 1-800-359-2002 تماس بگیرید.

Русский (Russian):
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-359-2002 (телетайп: 711).

日本語 **(Japanese):**
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-359-2002 (TTY:711) まで、お電話にてご連絡ください。

(Arabic): العربية

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-359-2002 (رقم
هاتف الصم والبكم :711).

ਪੰਜਾਬੀ (Punjabi):
ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-800-359-2002 (TTY:711) 'ਤੇ ਕਾਲ ਕਰੋ।

ខ្មែរ (Mon Khmer, Cambodian):
ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-359-2002 (TTY:711)។

Hmoob (Hmong):
LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-359-2002 (TTY:711).

हिंदी (Hindi):
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-359-2002 (TTY:711) पर कॉल करें।

ภาษาไทย **(Thai):**
เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-359-2002 (TTY:711).