

5: Summary of Benefits Coverage (SBC)

The Patient Protection and Affordable Care Act has established many new requirements and standards for group health plans, including the requirement to create and distribute a uniform Summary of Benefits and Coverage (SBC). The purpose of the SBC is to provide standard information and uniform language across the health benefits business to allow consumers to easily compare options and select health plans. Members can access SBC's by visiting <http://apehp.com/forms-documents/>. A hard copy of the SBC can also be provided upon request, please call the Plan at (888) 670-8135 for a copy or if you have any questions about the SBCs. For more information regarding this healthcare reform provision, please visit www.healthcare.gov.

6: Proof of Coverage (Attach to this form)

The Plan reserves the right to request payroll information from you or your employer at any time to ensure that you meet or continue to meet the eligibility requirements of a full-time employee working 24 hours or more. The Plan also reserves the right to request a copy of the following documentation at any time for each eligible dependent: *Spouse- Marriage Certificate or Proof of Domestic Partnership or Civil Union Certificate (if applicable) / Handicapped or Disabled Proof of incapacity verification/ Dependent child(ren) - Birth Certificate, Adoption Papers and/or Legal documentation from the court / Any additional information to verify coverage*

7: Other Insurance / Coordination of Benefits Information

Are you covered under any other group health plan? YES NO

Are any of your dependents covered by any other group health plan? YES NO

If yes, complete details of other coverage must be noted in this Section. Otherwise, if you answered NO, please skip to section 8 of this form.

Part A: Divorce/Legally Separated. Please complete this part if you are divorced or legally separated, and you are applying for dependent coverage under this health plan. Otherwise, continue to Part B.

Date of Divorce/Separation _____

Name of Other Biological Parent _____ Date of Birth _____

*If divorced or legally separated **:*

- Divorce decree states other parent, _____, must provide health benefits.
 Divorce decree states joint custody with shared responsibility for medical expenses.
 Divorce decree does not specify parent responsible for medical expenses.
 Other, please explain _____

With what parent does the child(ren) reside? _____

***A copy of the section of the court decree pertaining to health coverage would be helpful to support your response.*

Part B: Other Coverage - Non Medicare. Please complete this section if you or any of your dependents are covered under any other group health plan.

Type of coverage: _____ Coverage Effective date: _____

Name of Policy holder: _____ Name of other Benefit Payer: _____

Address of other Benefit Payer: _____

List all eligible persons for whom you are applying for coverage under this Plan, who are covered by another plan:

Yourself Your Spouse Your Child (ren): List Names _____

Name and Address of Spouse's Employer: _____

Part C: Medicare Coverage

Person eligible for Medicare _____

Medicare #: _____ Effective Date of Part A: _____ Effective Date of Part B: _____

Reason for Medicare Coverage: Age 65 or older Disability ESRD, Date Dialysis Treatment Began: _____ / _____ / _____

8: Application & Authorization

I hereby authorize any physician, hospital, insurer, or other organization or person having any records, data, or information concerning health history or medical insurance/coverage for myself or my eligible family members to furnish such records, data, or information as may be requested by the Plan, or its duly authorized representative. A photocopy of this authorization shall be considered as effective and valid as the original.

I declare that I have read this application in full and that all statements contained in this entire form about me and my dependents are true and correct to the best of my knowledge and that no material information has been withheld or omitted. I understand any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

I hereby apply for coverage on behalf of myself and eligible dependents listed on this form.

I hereby accept responsibility for payment of any portion of the Employee Contribution, if applicable, which I am required to pay, as well as any deductibles, copayments and coinsurance applicable under my Plan. Failure to remit payment will result in the immediate termination of coverage for myself and covered dependents. I further acknowledge that coverage shall become effective only if approved by the Plan Sponsor/Plan Administrator and only for services which are rendered on or after the effective date of coverage.

By providing my e-mail address, I hereby accept electronic delivery of all plan documents to my e-mail address. Plan documents include but are not limited to Health Care Quality Act, HIPAA Privacy Notice, Medicare Part D Notices, Summary Annual Report, Summary of Benefits and Coverage, Summary Plan Description, and Women's Health and Cancer Rights Act. Occasionally, in addition to electronic communications I may also receive a paper copy document. I understand that I can request a paper copy, free of charge, at any time by calling the plan. I can withdraw from the electronic delivery process at any time in the future by calling the plan. I can opt out of the electronic delivery process at this time by checking the box here:

Date _____ Employee Signature: _____

9: To be completed by Employer

I am either the employer or a representative authorized to execute this form.

Employer Representative Signature: _____ Proof of Coverage Satisfied (Check box):