hps solutions
NO PRE-PAYMENT REQUIRED FOR HPS PROVIDERS

PRAIRIE STATES

BRILLION PUBLIC SCHOOLS

Enrollment Application & Participant Agreement

Location: ☐ 001 – Active ☐ 002 – Retiree ☐ 003 – COBRA	
Medical Coverage Desired: ☐ Single ☐ Family	
Hire Date:	Effective Date:
Type of Change: ☐ New Enrollment ☐ Cancel Coverage ☐ Address ☐ Transfer ☐ Add/Drop Dependent(s)	

First Name:	MI:	Last Name:	
Home Address:	City	State:	Zip Code:
Gender: ☐ Male ☐ Female	Date of Birth:	Marital Status: ☐ Single ☐ Married ☐ Divorced	
Social Security Number:	Home Phone Number:	Cell Phone Number:	
Email Address:			

DEPENDENT INFORMATION INCLUDING OTHER COVERAGE – Please choose either "yes" or "no." Do not leave blank.

Last Name	First Name	MI	Gender	Date of Birth	Social Security Number	Please answer for you, your spouse, and for each dependent whether they have coverage under any other Medical Health Plan or policy including Medicare or Medicaid. If yes, please name plan and indicate if Plan is Primary or Secondary.
Employee						☐ No ☐ Yes If yes, ☐ Primary ☐ Secondary Name of Plan:
Spouse						☐ No ☐ Yes If yes, ☐ Primary ☐ Secondary Name of Plan:
Dependent 1						☐ No ☐ Yes If yes, ☐ Primary ☐ Secondary Name of Plan:
Dependent 2						☐ No ☐ Yes If yes, ☐ Primary ☐ Secondary Name of Plan:
Dependent 3						☐ No ☐ Yes If yes, ☐ Primary ☐ Secondary Name of Plan:

AUTHORIZATION

On behalf of myself and anyone enrolled on or added to this Enrollment Application and Participant Agreement, I authorize any healthcare professional or entity to give Health Payment Systems, Inc. and its affiliates or any of their designees, any and all records or information pertaining to medical services rendered to Us for any administrative purpose, and I authorize on behalf of Us the use of a social security number or other employee identification number for identification purposes. I HEREBY ACKNOWLEDGE THAT I HAVE READ THE TERMS OF THE PARTICIPANT AGREEMENT SET FORTH ON THE REVERSE SIDE OF THIS APPLICATION, AND I AGREE TO BE BOUND TO THE TERMS OF THE PARTICIPANT AGREEMENT.

Employee Signature: _____ Date: _____

WAIVER OF GROUP INSURANCE

I hereby acknowledge that I have been given the opportunity to apply for group insurance as offered by my employer or after being enrolled in the health insurance coverage, I have decided:

☐ I waive (do not want) coverage for: *or* ☐ I cancel coverage for: ☐ Myself ☐ My spouse ☐ My children

Reason for Refusing / Canceling Coverage: ☐ Spouse's Plan ☐ Other

If you are declining enrollment or canceling coverage for yourself or your dependents (including your spouse) because of other health insurance coverage, and, if in the future you lose such coverage under certain circumstances listed in the Plan Document, you will be able to enroll yourself or dependents in this Plan within 31 days of losing such coverage. Not all loss of coverage gives you this special right. For example, if you or your spouse drops the other coverage because you think it is too expensive, this does not give you special enrollment rights.

Employee Signature: _____ Date: _____

WHAT THIS DOCUMENT IS. This is a copy of Your Agreement with Us covering the use of your Account. *Please read this Agreement and keep it for your records.*

MEANING OF CERTAIN WORDS. When the words listed below are used in this Agreement, they have the meanings shown below:

"Account" means your Single Payment System℠ Claim payment account with Us.

"Benefit Program" means the contract, policy or other document(s) evidencing the healthcare plan provided to You by Your Employer, under which Your Employer is obligated to provide healthcare benefits on Your behalf.

"Claim" means a claim for payment of healthcare goods or services provided to You by a Provider, which is paid to the Provider through the Single Payment System℠.

"Participant Claim Payment" means the amount of liability that You have, arising from a Claim, as the result of deductible, co-payment and co-insurance requirements under Your Benefit Program.

"Payment Due Date" means that date thirty (30) days after the date of your monthly Account statement.

"Single Payment System℠" means Our system for paying Claims, including Participant Claim Payment amounts, to a Provider, within approximately twenty (20) days after We receive a properly prepared Claim.

"Provider" means those healthcare providers, physicians, and other healthcare professionals and facilities that contract with Us to participate in the Single Payment System℠.

"You," "Your" and "Yours" means yourself, your spouse, and any dependent of yours who is covered by Your Benefit Program and who receives healthcare goods or services, the Claims for which are paid through the Single Payment System℠.

"We," "Us," and "Our" means Health Payment Systems, Inc. ("HPS"), its agents and assigns.

YOUR PROMISE TO PAY. You promise to pay Us, in the manner called for by this Agreement, the full amount of all Participant Claim Payments that are paid to Providers on behalf of You, Your spouse and any dependent of Yours who is covered by Your Benefit Program through the Single Payment System℠. All payments must be in U.S. Dollars and must be made in full and as directed by Us, no later than the Payment Due Date shown on Your monthly Account statement. If you object to the payment of a Claim as erroneous, your obligation to pay the disputed Claim will be suspended pending a Claim audit and dispute resolution as provided in this Agreement.

PAYMENT BY CHECK. When you pay Us by check, you expressly authorize Us, if your check is dishonored or returned for any reason, to electronically debit Your checking account for the amount of the check plus a processing fee of $30 (or legal limit, if less). The use of a check for payment is Your acknowledgement and acceptance of this policy and its terms.

PAYMENT OF CLAIMS. You agree to be responsible for the payment of all Participant Claim Payment amounts, subject to your right to dispute such amounts as provided in this Agreement.

NOTICE OF ASSIGNMENT. The receivables from Participant Claim Payment amounts paid to Providers through the Single Payment System℠ are automatically assigned by the Provider to HPS for collection from You, and You acknowledge and agree to such assignment and to any modification to the payment terms of such receivable that may be necessary to reflect the terms set forth in this Agreement.

COOPERATION IN COORDINATION OF BENEFITS. You agree to complete and submit Coordination of Benefit forms identifying any Benefit Program, insurance or other party ("Alternate Payors") that may be responsible for the payment of all or any portion of any of Your Participant Claim Payment amounts and to provide such information as may be reasonably necessary to enable HPS if it deems appropriate to bill any Alternate Payor in order to appropriately coordinate benefits. You agree to complete Coordination of Benefit forms at the time of enrollment in Your Benefit Program and no less frequently than annually thereafter. You also agree to notify Your Employer of the existence of any Alternate Payors that may be responsible for the payment of all or any portion of any of Your Participant Claim Payment amounts in the event that You suffer an injury or condition requiring medical attention as the result of any accident (either in the workplace or otherwise).

REIMBURSEMENT OF HPS. You agree to reimburse Us for any Participant Claim Payment amounts paid to Providers. In the event it is ultimately determined that an Alternate Payor is responsible for the payment of all or any portion of any of Your Participant Claim Payment amounts HPS will assist You in efforts to pursue Coordination of Benefit claims against any such Alternate Payor for any Participant Claim Payment amounts.

WAIVER OF OBJECTION RIGHTS. You agree that all objections and defenses to the payment of any of Your Participant Claim Payment amounts shall be waived in the event that You have not provided Us with a written objection within one hundred eighty (180) days after the Provider has received such payment.

DISPUTE OF CLAIM PAYMENT AMOUNTS. With respect to any Claim payment made to a Provider on Your behalf, You, Your employer, or the Provider may object to the amount of such payment as erroneous, provided such objection is made within one hundred eighty (180) days after the Provider has received such payment. No party shall have a right to dispute the correctness of the amount of any Claim payment or Participant Claim Payment if such objection is not raised within one hundred eighty (180) days after the Provider receives the disputed payment.

CLAIM AUDIT AND DISPUTE RESOLUTION. You and each Provider shall have the right to object to the amount of the payment of a Claim and to audit such Claim as erroneous subject to the time limitations set forth in the preceding paragraph. You agree to cooperate with Providers and with HPS in connection with any Claim audit. In the event of a Claim payment dispute between You and a Provider, HPS, Your employer, and the Provider shall make good faith best efforts to facilitate resolution of the dispute, and shall provide access to records and personnel reasonably necessary to support resolution of the dispute.

CLAIM PAYMENT ADJUSTMENTS AFTER DISPUTE RESOLUTION. Upon resolution of a Claim payment dispute: (i) in the event that it is determined that such Claim has been underpaid, You shall make payment to HPS of the underpaid Participant Claim Payment portion of such Claim amount within ten (10) Business Days after such dispute resolution; and (ii) in the event that it is determined that such Claim has been overpaid, HPS shall authorize a credit or refund of such overpaid Participant Claim Payment portion of such Claim amount from the Provider to You within ten (10) Business Days after such dispute resolution.

CONSENT TO DISCLOSURE OF HEALTH INFORMATION. You consent to the release and disclosure of Your medical and health information to Us.