

Employer Information - This section to be completed by your employer.

Employer Name: _____ Employer Phone Number: _____
Group Number: _____ Division: _____ Class: _____ Department: _____

Employee Instructions: Please print in black ink. Please fill out the entire application for anyone applying for coverage. Remember, as the **employee**, you must be applying for coverage for anyone else in the family to be eligible.

I. Reason For Application

Please indicate if you are:

- A new group enrollee
- A new hire in an existing group (you must apply within your enrollment period) Requested Effective Date: _____
- An employee who previously waived coverage and is applying due to:
 - loss of other coverage - date: _____
 - birth of a child
 - adoption of a child
 - marriage
 - other: _____
- A late enrollee
- Adding a Dependent - Name: _____ Effective Date: _____
- Deleting a Dependent - Name: _____ Effective Date: _____
- Changing: Beneficiary to _____ Effective Date: _____
 - Other _____ to _____ Effective Date: _____
- Deleting Coverage (Explain): _____

II. Employee Information

Social Security Number _____ Occupation _____ Hours Worked Per Week _____
Last Name _____ First Name _____ Middle Initial _____
Address _____ City _____ County _____ State _____ Zip _____
Daytime Phone _____ Evening Phone _____ E-mail Address _____
What is the first day you worked/rehired full-time with your current employer? _____ Annual Salary \$ _____ Hourly Wage \$ _____
Are you: Single Married, Date Married _____ Divorced, Date Divorced _____ Widowed, Date Widowed _____
 Retired
 On COBRA Continuation - Reason _____ Start Date _____ Termination Date _____

If you or any of your dependents are entirely waiving coverage, please fill out Section IV. and VII.

III. Applicant Enrollment Information

Complete the following for all family members, beginning with you the employee, who are applying for coverage. If additional space is needed please attach a separate sheet with completed information.

← Complete for Patient Choice only →

Last Name	First Name	Middle Initial	Gender / Student Status	Relationship	Height Weight	Care System / Cost Tier
01	EMPLOYEE Name:		Gender: <input type="checkbox"/> M <input type="checkbox"/> F		H: _____ W: _____	Care System: _____ Cost Tier: _____
	Date of Birth: ___/___/___					
02	SPOUSE Name:		Gender: <input type="checkbox"/> M <input type="checkbox"/> F		H: _____ W: _____	Care System: _____ Cost Tier: _____
	Date of Birth: ___/___/___ Social Security #: _____					
03	Dependent Name:		Gender: <input type="checkbox"/> M <input type="checkbox"/> F Full Time Student: <input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Grandchild	H: _____ W: _____
	Date of Birth: ___/___/___ Social Security #: _____					
04	Dependent Name:		Gender: <input type="checkbox"/> M <input type="checkbox"/> F Full Time Student: <input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Grandchild	H: _____ W: _____	Care System: _____ Cost Tier: _____
	Date of Birth: ___/___/___ Social Security #: _____					
05	Dependent Name:		Gender: <input type="checkbox"/> M <input type="checkbox"/> F Full Time Student: <input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Grandchild	H: _____ W: _____	Care System: _____ Cost Tier: _____
	Date of Birth: ___/___/___ Social Security #: _____					

IV. Coverage Options

Please check the coverage(s) you are applying for below. Availability of coverage(s) is based on your group's plan of insurance. If anyone named in this application is waiving/declining coverage, please complete Section VII.

Type of Coverage	Applying For	Waiving/Declining this Coverage For
Group Medical Coverage <input type="checkbox"/> CMM Plan <input type="checkbox"/> PPO Plan <input type="checkbox"/> HSA Plan Please list the name of the Preferred Provider Network you choose (if applicable) _____	<input type="checkbox"/> Myself <input type="checkbox"/> My Spouse <input type="checkbox"/> My Dependents	<input type="checkbox"/> Myself <input type="checkbox"/> My Spouse <input type="checkbox"/> My Dependents
Group Term Life Coverage (Includes AD&D if selected by your employer)	<input type="checkbox"/> Myself	<input type="checkbox"/> Myself
Group Dependent Term Life Coverage	<input type="checkbox"/> My Spouse <input type="checkbox"/> My Dependents	<input type="checkbox"/> My Spouse <input type="checkbox"/> My Dependents
Group Voluntary Term Life Coverage (Includes Voluntary AD&D if selected by your employer)	<input type="checkbox"/> Myself \$ _____ or multiple of salary _____ <input type="checkbox"/> My Spouse \$ _____ <input type="checkbox"/> My Dependents	<input type="checkbox"/> Myself <input type="checkbox"/> My Spouse <input type="checkbox"/> My Dependents
Group Supplemental Term Life Coverage (Includes supplemental AD&D if selected by your employer)	<input type="checkbox"/> Myself \$ _____ <input type="checkbox"/> My Spouse \$ _____ <input type="checkbox"/> My Dependents	<input type="checkbox"/> Myself <input type="checkbox"/> My Spouse <input type="checkbox"/> My Dependents
Group Short Term Disability (STD) Coverage	<input type="checkbox"/> Myself	<input type="checkbox"/> Myself
Group Supplemental Short Term Disability (STD) Coverage	<input type="checkbox"/> Myself \$ _____ * Can't exceed 60% pre-disability Basic Weekly Earnings	<input type="checkbox"/> Myself
Group Voluntary Short Term Disability (STD) Coverage	<input type="checkbox"/> Myself \$ _____ * Can't exceed 60% pre-disability Basic Weekly Earnings	<input type="checkbox"/> Myself
Group Long Term Disability (LTD) Coverage <input type="checkbox"/> Base <input type="checkbox"/> Voluntary	<input type="checkbox"/> Myself	<input type="checkbox"/> Myself
Group Dental Coverage (Underwritten by Delta Dental) Please list the name of the provider you choose for Delta Care (DHMO) _____	<input type="checkbox"/> Myself <input type="checkbox"/> My Spouse <input type="checkbox"/> My Dependents	<input type="checkbox"/> Myself <input type="checkbox"/> My Spouse <input type="checkbox"/> My Dependents
Group Vision Coverage	<input type="checkbox"/> Myself <input type="checkbox"/> My Spouse <input type="checkbox"/> My Dependents	<input type="checkbox"/> Myself <input type="checkbox"/> My Spouse <input type="checkbox"/> My Dependents

If you are applying for life coverage, please provide name of primary beneficiary (if multiple, specify allocation%): _____

Relationship: _____ Address of Beneficiary: _____
(Street) (City) (State) (Zip Code)

Name of contingent beneficiary (optional): _____ Relationship: _____

V. Health Insurance and Medicare Information

- A. Will you or any family member(s) continue or maintain any other health or dental insurance or self-funded group medical plan in addition to the insurance being applied for today? Yes No
- B. List all health or dental insurance coverage in the last 270 days (18 months for late enrollees). Failure to provide coverage information may result in a pre-existing condition limitation.

Policyholder Information	Name, Address and Phone Number of Insurance Company / Plan	Policy or Group Number	Type of Coverage	Type of Plan	Effective Date of Coverage	Cancellation Date
Name: _____ <input type="checkbox"/> Employee <input type="checkbox"/> Spouse Date of Birth: _____			<input type="checkbox"/> Family <input type="checkbox"/> Single	<input type="checkbox"/> Medical <input type="checkbox"/> Dental		
Name: _____ <input type="checkbox"/> Employee <input type="checkbox"/> Spouse Date of Birth: _____			<input type="checkbox"/> Family <input type="checkbox"/> Single	<input type="checkbox"/> Medical <input type="checkbox"/> Dental		

You have a right to request a certificate of creditable coverage from your prior plan. If necessary, we will assist you in obtaining a certificate from the prior plan. If you received a certificate of creditable coverage from your prior plan, please attach a copy to this application.

- C. Are you or any of your family members eligible for Medicare? Yes No
If yes, please complete the following or attach a copy of your Medicare card.

Name of person covered by Medicare: _____ Medicare Claim Number: _____

Is Medicare eligibility due to: Over age 65 End-Stage Renal Disease (ESRD) Total disability

Effective Dates: Part A: _____ Part B: _____ Part C(Medicare Advantage): _____ Part D: _____

VI. Medical Information

A. Total Disability. Is anyone named in this application now disabled or unable to perform normal work - or age-related activities? Yes No

If yes, please identify names, conditions, dates of disability, and name and address of attending physician _____

B. Health Questionnaire. If you are enrolling for coverage(s) as part of a new group, please fill out the appropriate subsection below according to the number of employees *enrolled* in the group plan. You do not need to complete this questionnaire if you are enrolling as a new hire or late enrollee into an existing plan. Please note: you are required to forward to WPS any changes and/or developments in your or any family member's health history that occur prior to your receipt of our written underwriting decision on this application.

1. Groups With 51 to 249 Enrolled Employees.

a. Is anyone named in this application scheduled for an upcoming surgery? Yes No

If yes, please identify names, conditions, dates, details, and prognosis in the space provided below.

b. Within the last 12 months, has anyone named in this application been treated by a doctor or other practitioner or been diagnosed for heart or lung disorder, stroke, cancer, liver disorder, kidney disorder, diabetes, multiple sclerosis, connective tissue disorder, transplant or Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) (AIDS test received at anonymous counseling and testing sites or through home test kits need not be revealed - We are not seeking the results of HIV Antibody Test)? Yes No

2. Groups With 250+ Enrolled Employees.

a. Is anyone named in this application being considered for, on a list for, or scheduled for a transplant? Yes No

3. In the spaces below, please list medications and provide full details to questions for which you answered "yes" above. If you need additional space, please attach a separate sheet of paper.

Question No.	Family Member	Dates of Treatment	Identify the medication, condition, its duration, treatment, and degree of recovery	Name/Addresses of Attending Physician

VII. Waiver of Coverage

If anyone named on this application is waiving or declining any coverage, please provide his/her name and check the reason he/she is waiving/declining:

Name(s) of person(s) waiving/declining: _____

I am covered or will be covered under another plan that is not sponsored by my employer. I am not enrolled for coverage under Health Insurance Risk Sharing Program (HIRSP)

My dependents are covered or will be covered under another plan that is not sponsored by my employer. My dependents are not enrolled for coverage under Health Insurance Risk Sharing Program (HIRSP), Forward or Badger Care.

Other: _____

Waiver: I certify that I have been given the opportunity to apply for group coverage and decline to enroll as indicated on behalf of myself and/or my dependents. I understand that by signing this waiver, I and/or my dependents forfeit the right to coverage. If in the future I apply for coverage I or any of my dependents may be subject to exclusion of coverage for pre-existing conditions for a period of 18 months. This period may be offset by time covered under creditable coverage.

I understand that if I am declining enrollment for myself or my dependents (including my spouse) because of other health coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that I request enrollment within 31 days after my coverage ends. In addition, if I have a new dependent as a result of marriage, birth, adoption or placement for adoption, I understand that I may be able to enroll myself and my dependents provided that I request enrollment within 31 days after the marriage, birth or adoption. Any pre-existing waiting period that is in my policy will be offset by time served in a qualified plan.

Signature of Employee _____ **Date Signed** _____

VIII. Applying for Coverage

I am requesting the coverage(s) I have selected in Section IV. above under the group policy(ies) issued by, or which may be issued by, WPS/EPIC/Delta Dental (“the Insurer”), and I authorize my employer to deduct any required contribution to pay for the coverage(s) from my earnings.

CERTIFICATION: I represent and certify all of the following: • I am employed by the employer named herein and am working the number of hours indicated on the front of this application; • I have read and completed this entire application by myself, and that no other person, including the agent, completed any portion of this application; • I entered each and every answer myself in response to each request for information and/or question; • no answer or information written by myself in this application was provided by the agent or anyone else (except for information provided by other family members); • such representations are true, accurate, and complete to the best of my knowledge; • I and my spouse and dependent(s) have been given the opportunity to apply for the coverage(s) available to me (us) through my employer; • and I was not pressured nor forced by my employer, the agent or the Insurer into waiving/declining any coverage as shown in Section VII. above.

UNDERSTANDING: I understand: • the representations I make, together with any supplemental representations that I make, shall be the basis for the Insurer to issue any coverage; • that no agent has the authority to waive an answer to any question, pass on insurability, make or alter any contract, or waive or alter any of the Insurer’s other rights or requirements; • that no coverage will be effective unless and until the date specified by the Insurer after this application has been approved by the Insurer; • any misrepresentation contained herein may be used to reduce or deny a claim, void coverage, or void the group contract(s) within the contestable period, if such misrepresentation materially affects the Insurer’s acceptance of the risk; including approving any person for coverage; • if my death occurs before EPIC has approved in writing any EPIC coverage, the only death benefit provided shall be the lesser of the maximum amount available without evidence of insurability or the maximum amount I am eligible for, under the coverage(s) for which I was eligible.

I understand that the Insurer has no liability for anything the agent said or failed to say before, during, or after the application process, that’s not subsequently confirmed in writing by an authorized officer of the Insurer; including, but not limited to, answers given by the agent in response to questions asked by myself, my spouse or my dependent(s). Furthermore, I understand that the Insurer is not liable for any statement, representation, or other information provided to myself, my spouse or my dependent(s) that isn’t expressly contained in a written document provided to them and signed by an authorized officer of the Insurer.

I understand and acknowledge that any person who, with intent to defraud or knowledge that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false and deceptive statement is committing a fraudulent act, which is a crime. I further understand and acknowledge that in some states, any person who, for the purpose of misleading an insurer or other person, conceals significant information from an application or claim is committing a fraudulent act.

AUTHORIZATION TO RELEASE MEDICAL RECORDS: I hereby authorize any licensed physician, medical practitioner, health care provider, hospital, clinic, or other medical or medically related facility, insurance or reinsuring company, Medical Information Bureau, Inc. (“MIB”), consumer reporting agency, or other organization, institution, or person that has any record or knowledge of me or my minor children to give to the Insurer or its legal representative, reinsurers, authorized agents or designees, any and all information (including information that constitutes protected health information as defined in the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996, as amended (“HIPAA Privacy Regulations”), but excluding psychotherapy notes, if any) in any form, including, but not limited to, in original, electronic, or photographic copies, about me or my minor children to be covered concerning diagnosis, treatment and prognosis for any physical or mental condition, history or character, general reputation, personal traits, and mode of living, including, but not limited to, all medical and health care records. The information authorized for release shall not include whether the individual has obtained a test for the presence of HIV, antigen or nonantigenic products of HIV or an antibody to HIV or the results of such a test, if obtained by the individual.

I understand the information obtained by this authorization will be used by the Insurer to determine eligibility for coverage under my employer’s group policy(ies) and that my failure to authorize the release of said information may result in a refusal to issue or provide coverage. I agree that the Insurer may release said information to MIB or to the Insurer’s reinsuring companies, representative(s) or other person(s) performing business or legal services in connection with this application or as may be permitted or required by law, or as I may further authorize from time to time.

I understand I may revoke this authorization by providing advance written notice of termination to WPS at its office in Madison, Wisconsin, and that any information released in reliance on this authorization and prior to such revocation cannot be retrieved. In such case, WPS, its directors, officers, employees and agents shall not be held responsible or liable for such release. I understand this authorization will remain valid for 30 months from the date I execute this authorization unless this authorization is revoked by me in writing prior to the end of that 30-month period.

I understand that I am entitled to receive a copy of this completed, signed authorization, and that a photographic copy shall be as valid as the original. I understand that once information is disclosed pursuant to this authorization, it may no longer be protected by the HIPAA privacy Regulations and could be re-disclosed by the person or entity that receives it.

Has any person assisted you in the completion of this form? Yes No **If yes, please print name:** _____

Applicant’s Signature _____ **Date Signed** _____

Spouse’s Signature (if applicable) _____ **Date Signed** _____

NOTICE OF SPECIAL ENROLLMENT RIGHTS FOR HEALTH COVERAGE

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose coverage (or if the employer stopped contributing towards your or your dependents' other coverage).

Loss of coverage events include, but are not limited to: (a) the person no longer lives, resides or works within his or her HMO service area, the HMO does not provide coverage for that reason and there is no other coverage under the plan for the individual; (b) a dependent loses dependent status because he or she attains a particular age; (c) the plan no longer offers any benefits to a class of similarly-situated individuals (such as if the plan terminates coverage for all part-time workers); and (d) a benefit package option terminates or the issuer stops operating in the group market. In addition, if a claim is denied because a person has reached a lifetime limit on benefits, Health Insurance Portability and Accountability Act (HIPAA) regulations deem that to be a loss of eligibility for coverage for special enrollment purposes.

However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact:

MEMBER SERVICES DEPARTMENT
SUPERVISOR ADMINISTRATIVE OPERATIONS
TELEPHONE NUMBER: 1-800-748-0575

This Notice is not a part of the application. This Notice is for informational purposes only and is informing you of your special enrollment rights. Please detach this Notice before submitting the application to us.

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