



18000 West Sarah Lane, Suite 310, Brookfield, WI 53045
 or 3315C North Ballard Road, Appleton, WI 54911

Email completed form to: enrollmentchanges@trilogycares.com or Fax completed form to: (262) 432-0396
ENROLLMENT/CHANGE/WAIVER FORM

(Please print or type)

Group Name: _____ Group Number: _____ Effective Date of Coverage: _____

EMPLOYEE INFORMATION

Legal Last Name _____ Legal First Name _____ Full Middle Name _____

Street Address _____ City _____ State _____ Zip _____ County _____

Work Phone _____ Home Phone _____ Email Address _____

COVERAGE INFORMATION

Gender: Male Female Date of Birth: _____ Social Security Number: _____

Employee Status (check all that apply): Full-time Active Employee Retired
 Union Non-Union Salary Hourly Management Non-Management

Date Employed Full-time: _____ Average Hours Worked per Week: _____ Height/Weight: _____

Reason for Enrollment:

New Group Open Enrollment Late Enrollment, Reason: _____
 New Hire, Date of Hire: _____ Special Enrollment (Change in Coverage-Select Appropriate Reason Below)

Changes and Reason for Changes:

Adding Dependent(s) Name(s): _____ Reason: _____ Effective Date / /

Deleting Dependent(s) Name(s): _____ Reason: _____ / /

COBRA/State Continuation Name(s): _____ Reason: _____ / /

Qualifying Event: _____

Start Date of COBRA/Continuation: _____ Termination Date of COBRA/Continuation: _____

Terminate ALL coverage Reason: _____ / /

Name Change from: _____ to: _____ / /

Address/Telephone Number Change: _____ / /

Transfer from Group Number: _____ to Group Number: _____ / /

Type of Coverage Requested: Employee Only Employee & Spouse Employee & Child(ren) Family

FAMILY INFORMATION (List only family members to be covered)

Legal Name-Last, First, Middle	Relationship to Employee <small>(i.e. Spouse, Son, Daughter or Other. If other, explain)</small>	Gender (M/F)	Date of Birth (Month/Day/Year)	Social Security Number	Height/Weight	If over age 18 & Full time Student, indicate Name of School & Graduation Date
1:						
2:						
3:						
4:						
5:						

HEALTH HISTORY QUESTIONNAIRE – (Complete only if Employer Group is applying for New Coverage)

1. Yes No Within the past 24 months, have you or any dependent to be covered been hospitalized, or are you or any dependent to be covered scheduled to be hospitalized within the next 12 months?
2. Yes No Within the past 24 months, have you or any dependent to be covered incurred claims in excess of \$10,000?
3. Yes No Are you or any dependent to be covered currently disabled, pregnant, receiving treatment, taking medication, using tobacco products or been advised of a condition that will require attention in the next 12 months?
4. Yes No Within the past 24 months, have you or any dependent to be covered, been diagnosed or had treatment for any of the following: *(Check all that apply)*

<input type="checkbox"/> Cancer/Tumor	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart/Blood/Vascular Disorder	<input type="checkbox"/> Mental or Emotional Disorder
<input type="checkbox"/> Alcohol or Drug Abuse	<input type="checkbox"/> Kidney Disorder	<input type="checkbox"/> Liver Disorder	<input type="checkbox"/> Respiratory/Lung Disorder
<input type="checkbox"/> Stroke	<input type="checkbox"/> Intestinal Disorder	<input type="checkbox"/> Ear/Eye Disorder	<input type="checkbox"/> Skin Disease
<input type="checkbox"/> Transplant	<input type="checkbox"/> Growth Disorder	<input type="checkbox"/> Breast Disorder or Breast Implants	<input type="checkbox"/> Infertility
<input type="checkbox"/> Genital/Urinary Disorder or Deformity		<input type="checkbox"/> Enlarged Lymph Nodes or other Immune System Disorder	
<input type="checkbox"/> Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)			
<input type="checkbox"/> Muscular or Systemic Disease (included but not limited to arthritis, lupus and multiple sclerosis)			

Provide details to "YES" answers in the table below. (If more space is needed, attach an additional sheet of paper, sign and date):

Question Number	Name	Illness/Impairment If Pregnant, list due date	Dates Treated	Medications/Treatment/Surgery/Treating Physician

COORDINATION OF BENEFITS – OTHER GROUP COVERAGE

On the date this coverage will begin, will any family member(s) be covered by any other medical insurance plan? Yes No
If yes, please provide details about other available coverage in the section(s) below:

1. Subscriber Name: _____ Birth Date: _____ Social Security Number: _____

Name of persons covered under other insurance:	Relationship to subscriber: Child, Step Child or Other-please explain
1: _____	_____
2: _____	_____
3: _____	_____

Is this Policy offered through an employer? Yes No

Name of Employer: _____	Policy and Member ID: _____
Name, Address and Telephone Number of Insurance Company _____ _____	Effective Date of Policy/Plan: _____
	Termination Date of Policy/Plan: _____

Type of Plan: Group Policy Individual Policy Medicare Medicaid Other: _____

Type of Coverage: Single Family Limited Family

Is there a divorce decree or court order that outlines insurance information, custody, or placement of any dependent children under this policy?
 Yes No If yes, a copy of the divorce decree or court order must be attached in order to ensure accurate payment of claims.

MEDICARE INFORMATION

Does anyone listed on this application currently have Medicare Coverage? Yes No If yes, complete information below and attach a copy of the Medicare ID Card.

Name of Person Covered by Medicare: _____ Medicare Claim Number: _____

Is Medicare Eligibility due to: Over Age 65 Total Disability End Stage Renal Disease (ESRD)

Date Disabled: _____ Date of Initial Treatment: _____ Part A Effective: _____ Part B Effective: _____

CONFIDENTIALITY AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize any health care provider to release any of my medical information, including that related to mental illness, to Trilogy medical and claims management personnel, when reasonably related to my application for coverage through Trilogy. This authorization related to my application is effective for 30 months from the date of my signature.

If accepted for coverage, I also authorize any health care provider to release any and all of my medical records, to Trilogy when reasonably related to coverage for quality measurement or administrative purposes. This authorization is valid while my coverage is in effect or for as long as a claim is pending, whichever is longer. I understand I am entitled to inspect and receive a copy of the released records and I may revoke these authorizations at any time except to the extent a healthcare provider has already acted in reliance upon them. I understand I am, or my authorized representative is, entitled to receive a copy of this completed form. If any law, provider, or entity other than those contracted by Trilogy to fulfill the obligations of its contract (namely auto, personal liability, workers' compensation, and/or health insurance carrier) requires additional authorization for release of medical records, I will be asked to sign a special consent for release of this information. I understand Trilogy will make every effort to protect my privacy at all times. I understand member identifiable information will not be shared with my employer unless authorized by "me", the member. In the event I am unable to give consent, Trilogy will require Guardianship papers.

**SIGNATURE REQUIRED
CONFIDENTIALITY AND DECLARATION OF STATEMENTS PROVIDED**

I understand failure to provide authorization for release of medical information to Trilogy may result in significant delays to the processing of my claims. I also understand Trilogy retains the right to release claims information received from health care providers to contracted entities (for example, recovery agencies, provider service organizations, etc.) to fulfill Trilogy obligations under group contract.

I understand the above answers will be relied upon by Trilogy in the issuance of a certificate of insurance. I declare all statements contained in this form are true and correct to the best of my knowledge and/or belief, and no material information has been withheld or omitted.

Employee Signature: _____ Date: _____

Spouse Signature: _____ Date: _____

Dependent Signature (if over age 18): _____ Date: _____

Dependent Signature (if over age 18): _____ Date: _____

WAIVER (Complete this section and the Employee Information section on page1, if you or any dependents are waiving coverage.)

I waive coverage for: Self Spouse Dependent(s)

If waiving coverage please complete the following:

Existence of other health coverage Spousal coverage Other: _____

I certify I have been given the opportunity to apply for group coverage available to me and decline to enroll on behalf of myself and dependents, if any. I also certify I was not pressured or induced by my employer, the writing agent, or Trilogy to decline. I understand by signing this waiver, I forfeit my right to coverage and should I decide to apply later, I may do so; however, I may be considered a Late Enrollee. I further understand if I am considered a Late Enrollee, I may be declined from coverage, excluded from coverage for a period of time, or subject to pre-existing limitations as defined in and where permitted by law and I may be required to provide, where allowed by law, Medical History satisfaction to Trilogy for myself and/or my dependents.

If I have waived coverage for myself and/or my dependents (including my spouse) because of other health insurance coverage, I may in the future be able to enroll myself and/or my dependents in the policy, provided I request enrollment within 31 days after my coverage ends because of involuntary loss of the coverage (divorce, death, legal separation, termination of employment, reduction in number of hours of employment). In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll my dependents, provided I request enrollment within 31 days after the date of the event.

Employee Signature: _____ Date: _____

Submit the Enrollment/Change/Waiver Form to Trilogy Health Insurance:

- **Via Email:** Attach the completed form and send the email to enrollmentchanges@trilogycares.com.
- **Via Fax:** Fax the completed form to 262-432-0396 ~ Attn. Customer Service.
- **Via Mail:** Trilogy Health Insurance, Attn: Customer Service, 18000 W. Sarah Lane, Suite #310, Brookfield, WI 53045