

- WPS Individual Preferred Plan
- WPS HSA-Qualified High-Deductible Health Plan



INDIVIDUAL POLICY NEW APPLICATION

Use the Postage-Paid Envelope or Mail This Application To:
Wisconsin Physicians Service Insurance Corporation
P.O. Box 7898—Madison, WI 53707

INSTRUCTIONS: Please complete the entire application. Please print using black ink. WPS/Delta Dental of Wisconsin (“the Insurer”) does **NOT** guarantee approval of this application for any person, or issuance of a policy. If you do not understand any questions on this application, please contact your Agent or WPS Individual Sales Representative.

1. Information About You (Applicant)

Your Name			<i>Last</i>	<i>First</i>	<i>Middle Initial</i>
Social Security Number	Birth Date	Sex	Height	Weight	Evening Phone Number
		<input type="checkbox"/> Male <input type="checkbox"/> Female			()
Address	<i>Number & Street</i>	<i>City</i>	<i>State</i>	<i>Zip</i>	<i>County</i>
					Daytime Phone
					()
Marital Status					Email Address
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed					
Occupation: _____					
How did you hear about this WPS Plan? _____					
May we contact you with any questions regarding the application using the daytime phone listed?				Did an agent or sales representative assist you in the selection of this plan?	
<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No	

2. Information About Your Family (If enrolling dependents, please complete this section)

Last Name	First Name	M.I.	Birth Date	Sex	Height	Weight	Social Security #	Occupation
Spouse								
Dependent Children							X	Relationship to applicant
								Relationship to applicant
								Relationship to applicant
								Relationship to applicant
								Relationship to applicant
								Relationship to applicant

3. Information on Eligibility

- A. Are you, your spouse, and every named dependent a citizen of the United States or resident legal aliens? Yes No
- B. Do you and your spouse reside in Wisconsin at least 6 months per year? Yes No

If you answer “No” to question A. or B. above, you are not eligible for the coverage and benefit plan you’re requesting. The Insurer won’t approve this application. Do not proceed further and do not submit this application to WPS.

4. Information About Other Medical Coverage

- A. Does any person applying for coverage currently have other individual or group health coverage? Yes No
If yes, answer question B. below.
- B. If approved for the coverage and benefit plan you’re requesting, do you wish to cancel your other individual or group health coverage and replace it with the requested coverage and benefit plan? Yes No
If you answered “Yes” to question B. above, please complete Section 10 of this application.
If you answered “No” to question B. above, you are not eligible for the coverage and benefit plan you’re requesting. The Insurer won’t approve this application. Do not proceed further and do not submit this application to WPS.
- C. Are you or any of your dependents eligible for Medicare? Yes No
Name(s) _____

Persons who are eligible for Medicare are not eligible for the coverage and benefit plan you’re requesting. WPS won’t approve these persons for coverage. If the applicant is such a person, do not proceed further and do not submit this application to WPS.

5. Type of Coverage and Benefits Plan

A. Choose Type of Coverage:

- Applicant Applicant & Spouse Applicant and Children Applicant, Spouse, and Child(ren)

B. Choose your Preferred Provider Network:

Provider Network Name

C. Choose your Health Benefit Plan:

Individual Preferred Plan

Deductible (choose one): \$500 \$1,000 \$1,500 \$2,000 \$2,500 \$3,500 \$5,000 \$6,000 \$7,500

Coinsurance (choose one): 90%/70% of the next \$5,000 90%/70% of the next \$10,000 100%/80% of the next \$5,000
 80%/60% of the next \$5,000 80%/60% of the next \$10,000

Drug: If you selected the \$500, \$1,000, \$1,500 or \$2,000 deductible option, choose one of the following:

- \$15/\$40/\$60 copay No Drug Coverage

If you selected the \$2,500, \$3,500, \$5,000, \$6,000 or \$7,500 deductible option, choose one of the following:

- \$250 deductible, then 50% No Drug Coverage

HSA-Qualified High-Deductible Health Plan

Deductible (choose one)

- \$1,200 Single, \$2,400 Family \$2,500 Single, \$5,000 Family \$3,500 Single, \$7,000 Family
 \$1,500 Single, \$3,000 Family \$3,000 Single, \$6,000 Family \$5,500 Single, \$11,000 Family
 \$2,000 Single, \$4,000 Family

Coinsurance (choose one)

- 100%/80% 90%/70%* 80%/60%**

*Only available on the \$1,200/\$2,400 deductible option

**Not available on the \$5,500/\$11,000 deductible option

Drug Coverage (choose one): Prescription drugs subject to preferred deductible and coinsurance

- No drug coverage

Waiver of Premium Option: Yes No

D. Choose your Dental Benefit Plan:

Dental Plan underwritten by Delta Dental of Wisconsin - The dental plan is only available if you select one of the health plans shown above.

Are you applying for dental coverage? Yes No

Does any person applying for coverage have other dental coverage that is not canceling and will not be replaced by the requested dental coverage? Yes No If you answered "Yes" to this question, you are not eligible for the dental plan coverage.

6. Information About You and Your Family's Health ANY MISREPRESENTATION MAY BE USED TO DENY A CLAIM OR TO RESCIND AND VOID THE POLICY.

Please do not include any AIDS virus antibody tests, except for the FDA-licensed blood tests taken and diagnosed by a member of the medical profession. Any tests performed at anonymous counseling and testing sites or through home test kits are confidential and need not be revealed on this application.

THE FOLLOWING QUESTIONS MUST BE ANSWERED EITHER "YES" OR "NO." PLEASE PROVIDE FULL DETAILS ON PAGE 4 FOR EACH "YES" ANSWER.

- A. Are you, your spouse or any dependent pregnant or an expectant mother or father (even if dependent coverage is not being requested)? Yes No
- B. Have you, your spouse or any dependent applying for coverage smoked cigarettes or used tobacco or nicotine in any form including smokeless tobacco within the past 12 months? Yes No
- C. Have you, your spouse or any dependent applying for coverage been diagnosed or been treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), diseases associated with AIDS, or other immune system disorders, or ever tested positive for antibodies to the Human Immunodeficiency Virus (HIV)? Yes No
- D. Have you, your spouse or any dependent applying for coverage ever: (1) had symptoms of, or been treated for, alcohol, substance or drug abuse or dependence; (2) been advised to limit or reduce the use of alcohol, chemicals, or other drugs or been a member of Alcoholics Anonymous; or (3) had any alcohol or drug-related arrest whether or not it resulted in a conviction? Yes No
- E. In the past 10 years, have you, your spouse or any dependent, when applying for medical, disability or life insurance with any company, ever been declined for coverage; had coverage postponed or ridered, whether or not a policy was issued; or had the premium increased due to health history? Yes No
- F. 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 physician.

6. Information About You and Your Family's Health (cont'd.)

G. **In the past 10 years** have you, your spouse or any dependent applying for coverage had symptoms of, been diagnosed, treated (including chiropractic treatment), or sought a medical opinion for any of the following even if you no longer have any current symptoms:

- | | | | | | |
|---|------------------------------|-----------------------------|--|------------------------------|-----------------------------|
| 1. Heart disease or disorder | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 44. Cancer | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Stroke | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 45. Tumor..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Circulatory disease or disorder..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 46. Cyst | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Chest pain | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 47. Polyp | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. High or low blood pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 48. Abnormal growth..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Elevated cholesterol and/or triglyceride levels..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 49. Carcinoma in situ..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. Anemia or blood disease or disorder | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 50. Eye disease or disorder | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. Ulcers | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 51. Ear disease or disorder..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 9. Stomach disease or disorder | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 52. Attention deficit disorder..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 10. Liver/pancreas disease or disorder | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 53. Psychological disease or disorder | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 11. Gallbladder disease or disorder | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 54. Depression | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 12. Intestinal disease or disorder (e.g., colitis, Crohn's) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 55. Anxiety..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 13. Hernia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 56. Nervous, mental or emotional disorder | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 14. Rectal disease or disorder..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 57. Suicide attempt | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 15. Diabetes..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 58. Eating disorder..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 16. Elevated blood sugar..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 59. Epilepsy or other seizures | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 17. Sugar albumin or blood in urine..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 60. Convulsions | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 18. Thyroid disease or disorder | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 61. Headaches | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 19. Adrenal disease or disorder | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 62. Nervous System disease or disorder | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 20. Enlargement of the lymph nodes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 63. Organ or other type of transplant..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 21. Connective tissue disease or disorder..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 64. Breast disease or disorder incl. fibrocystic breast(s) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 22. Allergy(ies) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 65. Sleep Disorder | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 23. Asthma | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 66. Sleep Apnea | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 24. Hayfever | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 67. Lupus | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 25. Emphysema..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 68. Arthritis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 26. Sinus or nasal disease or disorder..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 69. Fibromyalgia | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 27. Lung disease or disorder..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 70. Back disorder..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 28. Shortness of breath | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 71. Joint disorder/replacement/hardware..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 29. Pneumonia..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 72. Musculoskeletal disease or disorder | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 30. Menstrual disease or disorder | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 73. Skin disease or disorder..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 31. Genital disease or disorder | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 74. Acne | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 32. Sexual dysfunction | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 75. Throat disease or disorder | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 33. Infertility | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 76. Paralysis..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 34. Urinary tract disease or disorder..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 77. Spinal Cord disorder | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 35. Kidney disease or disorder | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 78. Chronic fatigue syndrome | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 36. Bladder disease or disorder..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 79. Hepatitis..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 37. Prostate disease or disorder | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 80. Multiple sclerosis..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 38. Abnormal Prostate Specific Antigen (PSA) results | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 81. Disease or disorder of brain..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 39. Disease or disorder of male or female sex organs .. | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 82. Any type of implant..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 40. Abnormal Pap smear results | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | |
| 41. Abnormal mammogram results | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | |
| 42. Sexually transmitted disease or disorder | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | |
| 43. Pregnancy complications (e.g., premature birth, miscarriage, c-section) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | |

H. **In the past five years** have you, your spouse or any dependent applying for coverage:

1. (a) Had either inpatient or outpatient surgery or been admitted to a hospital for a reason other than surgery; (b) been scheduled for or recommended for surgery which was not performed or which is scheduled to be, or recommended to be, performed in the future; (c) had a test of any kind (including, but not limited to, blood tests, x-rays, ultrasounds, and MRIs); or (d) been scheduled for a test or treatment, or had a test or treatment recommended, which was not performed or which is scheduled to be or recommended to be performed in the future?..... Yes No
2. Had an injury, accident, illness, medical attention, diagnosis, or treatment for any reason not already mentioned (except AIDS, HIV and genetic testing results)?
3. Consulted with or been treated by any physicians or other health care professionals (including chiropractors, podiatrists and osteopathic physicians) for any reason, including routine care, other than stated above?

I. Are you, your spouse or any dependent applying for coverage currently taking any medications recommended or prescribed by a physician or other health care practitioner?

If Yes, please list all medications and their dosage in the space provided on page 4. Yes No

J. Have you, your spouse or any dependent applying for coverage had a medication recommended or prescribed by a physician or other health care practitioner within the past 12 months?..... Yes No

If Yes, please list all medications and their dosage in the space provided on page 4.

GIVE DETAILS BELOW OF ANY “YES” ANSWERS TO QUESTIONS A.–H. IF MORE SPACE IS NEEDED, PLEASE ATTACH AN ADDITIONAL SHEET OF PAPER; PLEASE SIGN AND DATE THE ADDITIONAL SHEET.

Question	Name of Person	Illness or Health Condition <i>(Include diagnosis and prognosis)</i>	Dates Treated		Complete Name and Address of Physician Clinic, Hospital or Other Provider
			Beginning	Ending <i>(Indicate if ongoing)</i>	

GIVE DETAILS BELOW OF ANY “YES” ANSWERS TO QUESTIONS I. & J. IF MORE SPACE IS NEEDED, PLEASE ATTACH AN ADDITIONAL SHEET OF PAPER; PLEASE SIGN AND DATE THE ADDITIONAL SHEET.

Question	Name of Person	Name, Dosage and Frequency of Medication <i>(Include illness or health condition for which medication was prescribed)</i>	Dates Medication Taken <i>(Indicate if ongoing)</i>	Complete Name and Address of Prescribing Physician and Pharmacy

7. Agent Statement

I asked the applicant, spouse and all child(ren) over age 18 all questions contained in this application and recorded their answers exactly as given to me. I also represent that no other person provided any of their answers, or influenced any of their answers; if any of their answers were influenced by another person, I have attached a written explanation thereof to this application Yes No

Writing Agent's Name (Print) _____ Agent's Phone # _____

Writing Agent's Signature _____ Agent's Fax # _____

Writing Agent's License Number _____ Date Signed by Agent ____/____/____

WPS 9 Digit Agency ID Number _____ Agency Name _____

8. Policy Effective Date (If this application is approved by WPS, the policy effective date is determined only by WPS.)

The policy effective date shall be, as determined by the Insurer, **the later of:**

- A. If the application is received by the WPS Underwriting Department in Madison, Wisconsin, on the 1st through the 25th day of the calendar month, the policy effective date will be the first day of the following calendar month (for example, an application received on January 4th will receive a February 1st effective date).
- B. If the application is received by the WPS Underwriting Department in Madison, Wisconsin, on the 26th through the last day of the calendar month, the policy effective date will be the first day of the second calendar month following the calendar month in which the application is received (for example, an application received on January 26th will receive a March 1st effective date).
- C. The policy effective date requested by the applicant, provided the requested effective date is later than the dates stated in A. and B. above, but not more than 60 days following the date of application. **Requested Policy Effective Date:** ____/01/____ (Insert month and year.)

9. Your Premium Payment Options (Business checks and/or accounts cannot be used for premium payment.)

Please note: In an effort to comply with Small Employer Health Insurance Laws, we are unable to accept business checks for payment of premium.

Please check the mode of payment you're requesting in either A., B., or C. below

- A. **AUTOMATIC WITHDRAWAL.** We electronically transfer your premium directly from your bank account at the frequency you request. (If you select this option, please complete the Automatic Withdrawal Payment Authorization Form.)
 Monthly Quarterly Semiannually Annually
With this option, your first premium payment can be drafted from your bank account.
- B. **DIRECT BILL.** We send a premium notice directly to your home at the frequency you request. You return payment to WPS by the premium due date.
 Monthly (with a \$7.50 billing fee) Quarterly (with a \$7.50 billing fee)
 Semiannually (with a \$7.50 billing fee) Annually (with no billing fee)
- C. **CREDIT/DEBIT CARD.** (If you select this option, please complete Credit/Debit Card Authorization Payment Form.)
 Initial Premium Deposit Monthly Quarterly Semiannually Annually
With this option, your first premium payment can be charged to your credit card.

Premium Paid \$ _____ (If application is submitted through an agency, please complete Section 12.)

10. Certification/Understanding/Notice

CERTIFICATION: I represent and certify all of the following: • I have read and completed this entire application by myself, and that no other person, including the agent, completed any portion of this application unless indicated in Section 7; • 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.

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, or to rescind and void coverage and the policy within the contestable period, if such misrepresentation materially affects the Insurer's acceptance of the risk, including approving any person for coverage.

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.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

IF YOU ARE REPLACING OTHER INDIVIDUAL OR GROUP HEALTH COVERAGE, PLEASE READ THIS SECTION.

According to your application or the information furnished by you, you intend to lapse or otherwise terminate your present policy and replace it with a policy to be issued by WPS. For your own information and protection, certain facts shown below should be pointed out to you. If WPS approves your application for coverage and issues a policy, you should consider these facts before you lapse or terminate your present policy.


- Your new policy provides a time limit within which you may decide, without cost to you, whether you desire to keep the policy. The time limit is 10 days from the date of receipt of this policy.
- Health conditions which you presently may have might not be covered under the new policy. This change in coverage could result in a claim for benefits being denied under the new policy even though they are payable under your present policy.
- Although some of your present health conditions may be covered under the new policy, these conditions may be subject to certain waiting periods under the new policy before coverage is effective.
- Questions in the application for the new policy must be answered truthfully and completely; if not, the validity of the policy and the payment of any benefits thereunder may be rescinded and voided.

Cancel date of coverage being replaced _____

Name, address and telephone number of insurance company: _____

Policyholder name: _____ Policy number: _____

To the best of my knowledge and belief, I represent that all statements and answers I made in this application, and on the attached sheet (if any) are complete and true. I have read and understand this application, including the Certification/Understanding/Notice section above.

<p>(Please sign in black ink.)</p> <p>Sign Here  X</p>	_____	Applicant's Signature	_____	_____
	_____	Spouse's Signature	_____	_____
	_____	Child Over Age 18's Signature	_____	_____
	_____			_____
			_____	Date
			_____	Date
			_____	Date

11. Authorization Notice

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 regulation promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996, as amended ["HIPAA Privacy Regulation"], 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 this policy and that my failure to authorize the release of said information might result in a refusal to issue or provide coverage. I agree that the Insurer may release said information to MIB or to the Insurer 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 that I may revoke this authorization by providing advance written notice of termination to the Insurer, and that any information released in reliance upon this authorization and prior to such revocation cannot be retrieved. In such case, the Insurer, 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 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 Regulation and could be re-disclosed by the person or entity that receives it.

<p><i>(Please sign in black ink.)</i></p> <div style="display: flex; align-items: center; margin-top: 10px;"> <div style="margin-right: 10px;"> <p>Sign Here </p></div> <div style="font-size: 2em; font-weight: bold; margin-right: 10px;">X</div> </div> <div style="margin-left: 20px;"> <hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> <p>Applicant's Signature</p> <hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> <p>Spouse's Signature</p> <hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> <p>Child Over Age 18's Signature</p> </div>

12. Important Notice to Persons on Medicare

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS**

This is not Medicare Supplement Insurance.

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare Benefits when it pays:

- the benefits stated in the policy and coverage for the same event is provided by Medicare

Medicare generally pays for most of all these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

Before You Buy This Insurance

Check the coverage in all health insurance policies you already have.

For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

13. Conditional Receipt

No insurance agent or broker has the authority to waive or modify any term, condition or provision of this conditional receipt or of the application. An insurance agent or broker cannot approve or bind coverage, cannot guarantee the Insurer's approval or issuance of a policy, and cannot waive or alter any of the Insurers' other rights and requirements.

This conditional receipt is issued on the condition that any check, draft or other order for the premium payment by you to WPS be good and collectable, as determined by WPS.

NOTE: If you have not received a WPS policy or your premium payment is not returned within six weeks from the date shown above, please notify our WPS Member Services at the address shown on page 1. Please give us your name, the amount paid, the date of your payment and your application, the name of the person who received your payment, and the name of the writing agent who took your application.

Date: ____/____/____

Received from _____ the sum of \$ _____ paid as an advance premium deposit at the time of signing the application, dated the date shown above for a WPS health insurance policy. In such application, _____ is named as the applicant. WPS acknowledges receipt of this payment subject to the following conditions:

- A. If WPS determines, in accordance with its established underwriting rules and practices in effect on the date shown above, that one or more of the persons name in the application and proposed for coverage are insurable on such date for the policy and coverage applied for, WPS will issue a policy, contingent upon such coverage for such person(s) is approved by WPS, to the extent permitted by such rules and practices, with such policy's premiums determined accordingly by WPS.
- B. The effective date of any policy so issued will be the date determined by WPS. If, however, an issued policy is not accepted by the applicant upon delivery, such policy shall be deemed void from the beginning and no coverage shall be in effect at any time for any person.
- C. WPS will credit a future bill the excess, if any, of the sum shown above over the sum of the correct initial premium amount for any policy issued and accepted by the applicant.

Writing Agent (*Print Name*) _____ Signature of Agent _____

Agency Name _____ Agency ID No. _____

CREDIT/DEBIT CARD PAYMENT AUTHORIZATION FORM

A. Applicant Information

Last Name _____ First Name _____

WPS Customer Number (Social Security Number) _____ - _____ - _____

B. Billing Information, if Different Than Applicant

Name as it Appears on Credit/Debit Card _____

Mailing Address _____

City _____ State _____ Zip _____

Country _____

C. Premium Payment Mode

Select One: Initial Premium Deposit Only Initial Premium and Recurring (Please select a day from the 7th through 31st of the month for payment pull) _____

Note: Recurring premium payments will be charged to your credit/debit card on the day of the calendar month immediately preceding the premium due date, based on your selection. Recurring days available are the 7th through the 31st of the month. If a month does not contain the day you selected, payment will be pulled from your credit/debit card account on the last day of that month. We will continue to charge premiums until the policyholder notifies us to discontinue charging premiums in accordance with the WPS policy.

D. Credit/Debit Card Authorization

Select One: Visa MasterCard Discover Card

Credit/Debit Card Number
Must be from a personal account

_____/_____
Card Expiration Date

I hereby authorize WPS Health Insurance (WPS) or its authorized credit/debit card transaction agent(s) to bill my credit/debit card account indicated above for payment of premiums charged for the WPS insurance policy for which I'm applying. If that WPS individual policy is issued to me by WPS, I understand and agree that by executing this authorization, that action doesn't affect, waive, or change any of the policy's terms, conditions, and provisions, including that policy's premium payment and grace period provisions. I am attesting the credit/debit card listed above is a personal account; I understand the premium may not be paid from a business account.

(Please sign in black ink.)

Sign Here  **X**

Applicant's Signature

Date

FINANCIAL INFORMATION

AUTOMATIC WITHDRAWAL PAYMENT AUTHORIZATION FORM

By my signature below, I authorize Wisconsin Physicians Service Insurance Corporation (WPS) to instruct my financial institution to deduct my premium payments from the account designated below. I authorize my financial institution to debit the amount of my premium from my designated account. This authorization will remain in effect until I notify WPS in writing of its termination. My notification must afford WPS and my financial institution reasonable opportunity to act on it.

A. ACCOUNT HOLDER INFORMATION

Name _____

WPS Customer Number (if available) _____

Address _____

City _____ State _____ Zip _____

Social Security Number _____

Payment Mode:

Select One: Monthly Quarterly Semi-Annually Annually

B. FINANCIAL INSTITUTION INFORMATION

Institution Name _____

Branch/Location _____

Address _____


City _____ State _____ Zip _____

Select One: Checking Account* Savings Account

Please indicate the date in which you wish to have your premium payment withdrawn from your account _____
(If you do not indicate a date of withdrawal, the withdrawal date shall be the 20th of each month.)

Transit Number _____ Account Number _____

***IF USING A CHECKING ACCOUNT, PLEASE ATTACH A CHECK WITH "VOID" WRITTEN ACROSS IT.**

(Please sign in black ink.)
Sign Here  _____
Applicant's Signature

Date

FINANCIAL INFORMATION