INDIVIDUAL POLICY CHANGE APPLICATION

1717 W. Broadway–P.O. Box 7898
Madison, WI 53707
www.wpsic.com

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 ("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.

Customer Number ________________________________

Social Security Number ____________________________ **Policy Number** ___________________________________

1. Information Changes

A. CHANGE NAME

From: ____
Last First Middle Initial

To: ____
Last First Middle Initial

Effective Date of Change: ___________________________ (Check one:) ❑ Customer ❑ Spouse ❑ Dependent Child

B. CHANGE ADDRESS

Current Address: ____
Number and Street City County State Zip

New Address: ____
Number and Street City County State Zip

Effective Date of Change: ___________________________ New Phone Number (if applicable) ____________________

If you have moved to a different county, your Preferred Provider Plan network and rates, if applicable may be affected. Please contact your agent, or WPS Sales Representative.

C. CHANGE BENEFITS

1. Change Deductible and/or Coinsurance on Individual Preferred Plan

a. Deductible: Current Deductible: __________________
Change to: ❑ $500 ❑ $1,000 ❑ $1,500 ❑ $2,000 ❑ $2,500 ❑ $3,500 ❑ $5,000 ❑ $6,000 ❑ $7,500
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

b. Coinsurance: Current Coinsurance: __________________
Change to: ❑ 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

2. Change from Individual Preferred Plan to HSA Qualified High-Deductible Health Plan

a. Current Preferred Plan Deductible: __________________
Change Deductible to: (choose one)
❑ $1,200 Single, $2,400 Family
❑ $2,000 Single, $4,000 Family
❑ $3,000 Single, $6,000 Family
❑ $5,500 Single, $11,000 Family
❑ $1,500 Single, $3,000 Family
❑ $2,500 Single, $5,000 Family
❑ $3,500 Single, $7,000 Family

b. Current Preferred Plan Coinsurance: __________________
Change Coinsurance to: (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 deductible and preferred coinsurance
❑ No drug coverage

Waiver of Premium Option: ❑ Yes ❑ No

3. Change Deductible and/or Coinsurance on HSA Qualified High-Deductible Health Plan

a. Current Deductible: __________________
Change Deductible to: (choose one)
❑ $1,200 Single, $2,400 Family
❑ $2,000 Single, $4,000 Family
❑ $3,000 Single, $6,000 Family
❑ $5,500 Single, $11,000 Family
❑ $1,500 Single, $3,000 Family
❑ $2,500 Single, $5,000 Family
❑ $3,500 Single, $7,000 Family

1. Information Changes (cont'd.)

b. Current Coinsurance: ____________________

Change Coinsurance to: (choose one)

❑ 100%/80%

❑ 90%/70%* *Only available on the $1,200/$2,400 deductible option

❑ 80%/60%** **Not available on the $5,500/$11,000 deductible option

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

❑ No drug coverage

4. Change from HSA Qualified High-Deductible Health Plan to Individual Preferred Plan

a. Current Deductible: ____________________

Change to: ❑ $500 ❑ $1,000 ❑ $1,500 ❑ $2,000 ❑ $2,500 ❑ $3,500 ❑ $5,000 ❑ $6,000 ❑ $7,500

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, $6,500 or $7,500 deductible option, choose one of the following:

❑ $250 deductible, then 50% ❑ No Drug Coverage

b. Current Coinsurance: ____________________

Change to: ❑ 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

If you are increasing your deductible (example $500 to $1,000) and/or lowering your coinsurance, (example 90% to 80%) the effective date of the decrease for you and all your covered dependents shall be the first day of the calendar month following the receipt of this completed application by the WPS Underwriting Department in Madison, Wisconsin.

If you are decreasing your deductible (example $1,000 to $500) and/or raising your coinsurance (example 80% to 90%), you and your covered dependents are subject to our health underwriting requirements. You must complete Section 2. If WPS approves the change you are requesting, the effective date of the change will be assigned by WPS as stated in Section 3.

5. Dental Change:

❑ Add Delta Dental Plan underwritten by Delta Dental of Wisconsin – dental coverage is only available if you have selected medical coverage

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

❑ Delete Dental Plan

D. CHANGE PREFERRED PROVIDER PLAN NETWORK

Current Network: ____ New Network: ____

The effective date of the network change for you and all your covered dependents shall be the first day of the calendar month following the receipt of this completed application by the WPS Underwriting Department in Madison, Wisconsin. **Your rates may be affected if your new network is in a different rating zone. Please contact your agent, or WPS Sales Representative.**

E. CHANGE MATERNITY COVERAGE

Terminate Maternity Coverage Termination Date:_________/01/_________(NOTE: This option can not be added again in the future.)

F. CHANGE PREMIUM/PAYMENT MODE (Business checks and/or accounts can not 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.

Current Premium Mode: ______________________________________ Current Payment Mode: ______________________________________

Change to:

The effective date of the premium payment mode change shall be the first billing period following 30 days after we receive this change application.

❑ **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 premium payment can be drafted from your bank account.

❑ **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)

❑ **CREDIT/DEBIT CARD.** (If you select this option, please complete Credit/Debit Card Authorization Form.)

❑ Initial Premium Deposit ❑ Monthly ❑ Quarterly ❑ Semiannually ❑ Annually

With this option your premium payment can be charged to your credit card.

1. Information Changes (cont'd.)

G. CHANGING FROM SINGLE COVERAGE TO ANOTHER COVERAGE

Change from single coverage to: ❑ Applicant and Spouse Coverage ❑ Applicant and Child(ren) Coverage
❑ Applicant, Spouse, and Child(ren) Coverage

Coverage Change due to:

❑ Adding Newborn Child Newborn's Name____________________ Date of Birth __________
Last First Middle Initial

❑ Adding Adopted Child Child's Name ____________________ Date of Adoption __________
Last First Middle Initial
Date of Birth ____________________

❑ Adding Spouse Spouse's Name ____________________ Date of Marriage __________
Last First Middle Initial
Social Security # ____________________ Date of Birth __________

Height __________ Weight __________

If you are not adding a newborn or adopted child within the time limits stated in the policy, the newborn or adopted child is subject to our health underwriting requirements and, **you must complete Section 2**.

If you are adding a spouse, the spouse is subject to our health underwriting requirements and, **you must complete Section 2.** If we approve the coverage change you're requesting, the effective date will be the date of marriage if you applied within 30 days of the date of marriage. If you applied 30 days or more after the date of marriage, your effective date will be assigned by WPS as stated in Section 3.

❑ Adding Dependent Child (other than because of birth or adoption)

Child's Name ____________________ Date of Birth __________
Last First Middle Initial

Height ____________________ Weight ____________________

Relationship to You ____________________

Reason for Adding Dependent ____________________

If you are adding a dependent child other than a newborn or adopted child, that child is subject to our health underwriting requirements. **You must complete Section 2.**

If we approve the coverage change you're requesting, the effective date will be assigned by WPS as stated in Section 3.

H. ADDING DEPENDENT TO EXISTING FAMILY COVERAGE

❑ Adding Newborn Child Newborn's Name ____________________ Date of Birth __________
Last First Middle Initial
Height __________ Weight __________

❑ Adding Adopted Child Child's Name ____________________ Date of Adoption __________
Last First Middle Initial
Height __________ Weight __________ Date of Birth __________

❑ Dependent Child Child's Name ____________________ Date of Birth __________
Last First Middle Initial
Height __________ Weight __________ Reason for adding child __________

❑ Adding Spouse Spouse's Name ____________________
Last First Middle Initial
Height __________ Weight __________ Date of Birth __________

Spouse's Social Security Number ____________________ Date of Marriage __________

If you are not adding a newborn or adopted child within the time limits stated in the policy, the newborn or adopted child is subject to our health underwriting requirements and, **you must complete Section 2.**

If you are adding a spouse, the spouse is subject to our health underwriting requirements and **must complete Section 2.** If we approve the coverage change you're requesting, the effective date will be the date of marriage if you applied within 30 days of the date of marriage. If you applied 30 days or more after the date of marriage, your effective date will be assigned by WPS as stated in Section 3.

If you are adding a dependent child other than a newborn or adopted child, that child is subject to our health underwriting requirements. **You must complete Section 2.**

If we approve the coverage change you're requesting, the effective date will be assigned by WPS as stated in Section 3.

I. TERMINATING A DEPENDENT'S COVERAGE

Dependent Name______________________________ Date of Birth ____________

Relationship to You ______________________________

Date of Coverage Termination ______________________________

Reason for Coverage Termination ______________________________

J. CHANGING DEPENDENT STATUS

❑ Add Dependent as Full-Time Student:

Name of Dependent Child ______________________________

Name of College/University ______________________________

City and State of College/University ____________________ Number of credits for semester __________

Date Enrollment Began ______________________________

Is this dependent not providing 50% or more of his/her own support? ❑ Yes ❑ No

❑ Terminate Dependent Child as Full-Time Student:

Name of Dependent Child ______________________________

Date of Graduation or Termination of College/University Enrollment ______________________________

K. OTHER CHANGE

If a requested change is other than a change listed in Subsections A through J above, please explain below and **complete Sections 2 and 4.**

____

____

____

2. 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 6 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.

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

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? ❑ Yes ❑ No
If Yes, please list all medications and their dosage in the space provided on page 6.

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 6.

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 *(Include diagnosis and prognosis)*	Dates Treated		Complete Name and Address of Physician Clinic, Hospital or Other Provider
			Beginning	Ending *(Indicate if ongoing)*	

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 *(Include illness or health condition for which medication was prescribed)*	Dates Medication Taken *(Indicate if ongoing)*	Complete Name and Address of Prescribing Physician and Pharmacy

3. 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.)

4. Certification/Understanding

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 5; • 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 Insurers' 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 Insurers' 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.

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 section above.

(Please sign in black ink.)

Sign Here ⇨ X

Signature	Date
Applicant's Signature	Date
Spouse's Signature	Date
Child Over Age 18's Signature	Date

5. 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 ________________________

Street ________________________ City ________________ State ________ Zip ________

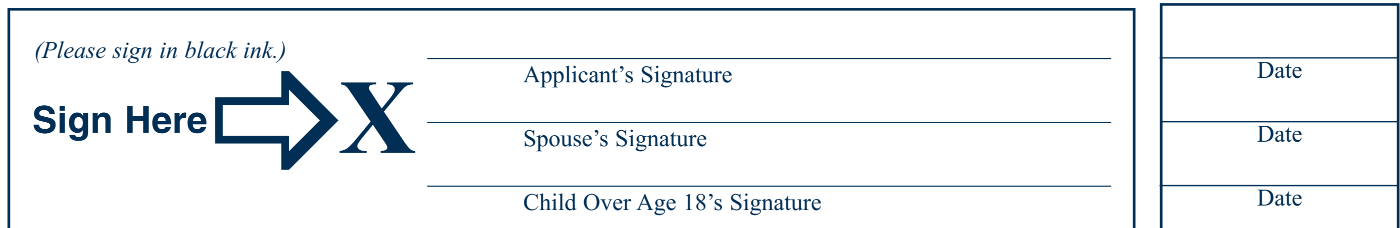
6. Authorization Notice

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 ["HIPPAA 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 WPS' 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.



CREDIT/DEBIT CARD 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

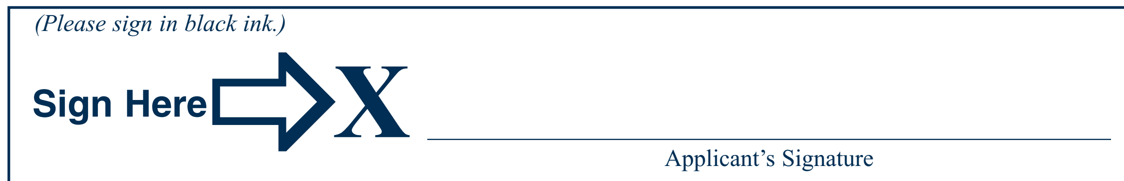
_________________________________ ______/______

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.)



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 ______________________________

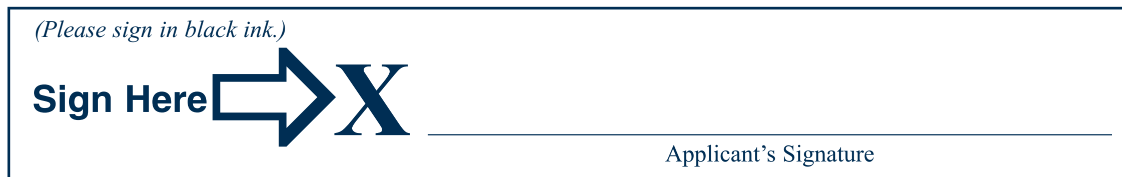
City ______________________________ State ____________ Zip ____________

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.**



FINANCIAL INFORMATION