

IV. Coverage Options

- Group Medical Coverage CMM PPO HSA Group Supplemental Accidental Death & Dismemberment (AD&D) Coverage
- Group Term Life Coverage Group Supplemental Short Term Disability
- Group Accidental Death & Dismemberment (AD&D) Coverage Group Supplemental Term Life Coverage
- Group Long Term Disability (LTD) Coverage Group Voluntary Short Term Disability (STD) Coverage
- Group Short Term Disability (STD) Coverage Group Voluntary Term Life Coverage
- Group Dependent Term Life Coverage Group Voluntary Accidental Death & Dismemberment (AD&D) Coverage
- Group Vision Coverage Other _____

Note: If applying for Dental Coverage, a Delta Dental Group Application must be completed

V. Change Information

- Employer Name Change: Employer's Former Name: _____
Employer's New Name: _____
 - Employer Address Change: Employer's Former Address: _____
Employer's New Address: _____
 - Employer's Coverage Change: (Complete Section I. and Section IV. If change is for life, LTD, or STD coverage, please also complete Group Benefit Request Form E10387)
- | Old Coverage | New Coverage |
|--------------|--------------|
| _____ | _____ |
| _____ | _____ |
- Change probationary period from _____ to _____
 - Explanation of any other change: _____

VI. Probationary Periods

Please provide any class descriptions for your group and check the appropriate probationary period for each class. Please note that groups with 2-50 enrolled employees can only have one probationary period.

A. Group Medical/Vision Coverage(s)

Employee Class Description

- Class 1 _____ 1st day of the calendar month following 1 2 3 4 5 * _____ months of full-time employment
- Class 2 _____ 1st day of the calendar month following 1 2 3 4 5 * _____ months of full-time employment
- Class 3 _____ 1st day of the calendar month following 1 2 3 4 5 * _____ months of full-time employment

B. Group Term Life/AD&D/STD/LTD Coverage(s)

Employee Class Description

- Class 1 _____ 1st day of the calendar month following 1 2 3 4 5 * _____ months of full-time employment
- Class 2 _____ 1st day of the calendar month following 1 2 3 4 5 * _____ months of full-time employment
- Class 3 _____ 1st day of the calendar month following 1 2 3 4 5 * _____ months of full-time employment

*Other options are available only to groups with more than 50 insureds.

VII. Specific Plan Information

A. What percentage of the monthly premium is to be paid by the employer for each of the following coverages: (Minimum Employer Contribution is 50% of employee premium.)

- 1. Group Medical _____ % per Employee _____ % per Limited Family (if available) _____ % per Family
- 2. Group Term Life/AD&D _____ % per Employee
- 3. Group Dependent Term Life _____ % per Spouse/Dependent
- 4. Group Long Term Disability (LTD) _____ % per Employee
- 5. Group Vision _____ % per Employee _____ % per Limited Family (if available) _____ % per Family
- 6. Group Short Term Disability _____ % per Employee

B. Please list the health care provider network(s) you're selecting for your group medical coverage (if applicable).

- 1. _____ 3. _____
- 2. _____ 4. _____

C. The applicable benefit options (deductible, coinsurance, annual out-of-pocket limits under group medical coverage; STD; age reduction; etc.) are the coverage and corresponding benefit options stated in the final, written quote and Group Benefit Request Form E10387 that was issued by WPS and/or EPIC and signed by the Employer's Representative in Section 10. below. If WPS and/or EPIC approves this application, the actual benefit options for this employer's group coverage(s) will be contained in the WPS and/or EPIC Certificate of Insurance(s) which is part of the group insurance policy(ies) issued by WPS and/or EPIC to the employer as the WPS and/or EPIC group policyholder.

D. For groups of 51 or more insured employees, the following additional classes are eligible for coverage: Retirees Part-time Employees

E. Other Special Requests/Comments: _____

VIII. About Your Current Plan

Will/does your company offer other group health coverage? No Yes

Are you replacing existing group health insurance? No Yes

Name of current group insurance carrier/administrator _____

Original effective date of coverage _____ Number of carriers in the last 5 years _____

If coverage was terminated, who terminated it? Employer Carrier Termination Date _____

Name of current worker's compensation carrier _____ Original Effective Date _____

IX. Premium/Billing

A check for \$ _____ made payable to WPS and/or EPIC ("the Insurer") is being submitted with this application as payment by this employer to be applied toward the initial month's premium if this application is approved by the Insurer and the group policy(ies)/coverage(s) is issued. The monthly premium billed by the Insurer will be due and payable to the Insurer on the first day of the coverage month.

Group Billing Options

- Automatic Withdrawal.** We electronically transfer your premium directly from your bank account monthly. If you select automatic withdrawal from your checking account, please attach a check with "VOID" written across it and complete the Authorization Agreement for Electronic Fund Transfer in Section XIII. of this application.
- Direct Bill.** We send a premium notice directly to your billing address monthly. You return the payment to WPS by the premium due date. An additional administrative fee will be added to your monthly bill if you select this option. Please see your quote for the administrative fee.

X. Employer Statement/Certification

The group medical coverage is guaranteed renewable. However, your group medical coverage could be canceled if the Insurer terminates all of its group medical insurance policies for this group class, or if you: • Fail to pay your monthly premium timely • Engage in fraud or misrepresentation • Breach the Insurer's group insurance policy(ies) • Fail to meet minimum participation requirements • Become ineligible as a group due to: (a) ceasing active business operation; (b) losing status of legal entity; or (c) moving the business to a state where this type of group medical insurance policy(ies) is not offered by the Insurer.

The Insurer may investigate the information on this application. Any findings may be used to deny coverage for one or more employees of the group or the entire group. Please indicate the name, title and telephone number of an employee in your firm who can provide necessary clarification of the employee and group information provided on this application.

Name _____ Position/Title _____ Telephone Number _____

I hereby certify that all information recorded in this application is true and complete to the best of my knowledge. I have been advised: • Not to terminate all existing coverage(s), whether on an insured or self-funded basis, unless and until the Insurer notifies me in writing that coverage(s) has been approved • the Insurer doesn't guarantee approval of this application or issuance of coverage(s) • This application or any coverage may be declined by the Insurer for a group size of 51 or more employees • The agent represents the employer, not the Insurer • Pre-existing conditions may be subject to waiting periods and other policy limitations and restrictions.

I understand that the Insurer will rely, in part, on the information provided in this application to issue or deny coverage(s). If the Insurer approves this application, I understand coverage(s) will become effective on the date assigned by them, no coverage(s) will be in force until that date.

I understand no agent or other person has the authority to alter; bind the Insurer, waive or change any terms, conditions, and/or provisions of the policy(ies) or any other requirement imposed by the Insurer. I understand the employer represents its employees and their dependents, not the Insurer. As the employer's authorized representative and acting on that employer's behalf, I understand, agree with, and approve each and every certification made by the agent in Section XI. Agent Certification of this application.

If this application is approved, I understand that the Insurer will not be, and are not, a plan sponsor, plan administrator, or fiduciary for any purpose under the Employee Retirement Income Security Act (ERISA) of 1974, as amended, or under any other state or federal law. I understand the employer is solely responsible for carrying out any obligation created, required, or imposed by ERISA or any other law, as it may apply to such group insurance policies

Signature of Employer Representative _____ Date _____

Signed at _____

City

State

XI. Agent Certification

I hereby certify and represent all of the following as being true: • I asked all questions accurately and fully recorded all information given by the Employer Representative in this application; • I advised the Employer Representative not to terminate existing coverage unless, and until the Insurer notifies him/her, in writing, that this application has been approved; • I used only advertising approved by the Insurer to solicit this application; • I told the Employer Representative nothing inconsistent with, or contrary to, the approved advertising about the benefits, group policy(ies) and/or coverage(s); • I didn't guarantee the Insurer's approval of this application or the Insurer's issuance of coverage(s); • I didn't tell the Employer Representative that the Insurer will cover any pre-existing condition(s) of any person proposed for coverage; and • I made no false, misleading, or deceptive statements or representations and complied with all applicable insurance laws, underwriting requirements, and the marketing/sales standards maintained by the Insurer.

I hereby certify and represent all of the following as being true: • I told the Employer Representative that the Insurer has no liability for anything I 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 me in response to questions asked by that Representative or anyone else; • I told the Employer Representative that the Insurer is not liable for any statement, representation, or other information provided to that Representative or anyone else that isn't expressly contained in a written document provided to them and signed by an authorized officer of the Insurer; • I understand that I'm liable for my acts and omissions to the extent provided by law; and • I understand I have no authority to alter this application, bind the Insurer by making promises and/or representations, or to waive or change the terms, conditions, and/or provisions of the group insurance policy(ies) or any requirement imposed by the Insurer.

Signature of Writing Agent _____ Date _____
Please Print Writing Agent's Name _____ Writing Agent's Social Security Number _____
Agency _____ Tax ID Number _____
Business Address _____
Agency Telephone Number _____ Agency Fax Number _____
Agency Number _____
WPS/EPIC Representative Name: _____

XII. Issue Information

Initial issue of contract documents are to be sent to: () District Office () Agency
() Employer () Other _____

IMPORTANT DID YOU REMEMBER TO INCLUDE:

- A copy of the WPS and/or EPIC quote.
- Completed and signed Employee(s) Group Enrollment Application for each eligible employee, both enrolling and waiving; if applicable.
- A check made payable to WPS and/or EPIC for the first month's premium
- A copy of the most recent bill (or certificate for those not listed on a bill) from the prior carrier or administrator.
- A copy of the group's most recent State Quarterly Wage and Tax Report (groups with 51 or more eligible employees should include a census of all full- and part-time employees).
- Completed EPIC Group Benefit Form E10387 for any other requested coverages.
- Completed Delta Dental Group Application if dental coverage is requested.

XIII. Authorization Agreement for Electric Fund Transfers

Group's Legal Name _____ Group Number _____

I hereby authorize Wisconsin Physicians Service Insurance Corporation, hereinafter called COMPANY, to initiate, if necessary, debit entries and adjustments for any credit entries in error to my: Checking Account Savings Account (select one)

indicated below and the depository named below, hereinafter called DEPOSITORY, to credit and/or debit the same to such account.

Depository Name _____ Branch _____

City _____ State _____ Zip _____

Transit Number _____ Account Number _____

This authority is to remain in force and effect until COMPANY has received written notification from me of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on said notice of termination.

Signature of Employer Representative _____ Date _____

Name and Title of Employer Representative (Please print) _____

Telephone Number _____

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