

**University Graduate Assistant Continuants Group Health Insurance Application**  
**Instructions for Dual-Choice Enrollment**

If you are an active employee, you may not use this application.

You must file this application by the end of the Dual-Choice Enrollment period if you want to change to a different health insurance plan or change to family coverage for the following year. If you wish to keep the same plan, but have other changes (e.g., adding or dropping a dependent, change of physician only, change of address or name) contact Employee Trust Funds to obtain the appropriate form.

Please read the instructions carefully. To avoid delays it is very important that you complete your application accurately.

1. **Name** – Complete your full name, including your middle name.
2. **Plan Name and Group No.** - This information is needed so that your current health insurance can be cancelled and your new plan can take effect. The group number can be found on your current health insurance I.D. card.
3. **New Group Health Insurance Plan Selected** - In this box write: "Standard Plan," or the name of the alternate plan you have selected.
4. **Other coverage** - Complete this indicating if you or anyone you list on your application is currently insured by another group health insurance policy. **This area must be completed in order to process the application.** If you or anyone you list on your application is enrolled in Medicare, list and provide Medicare effective dates.
5. **Persons to be covered** - Make sure you list each person to be covered under the health insurance plan you are selecting and include their Social Security numbers.
6. **Appl. Rel.** - Indicate your listed dependent's relationship to you (S-Son, D-Daughter, SS-Stepson, SD-Stepdaughter, G-Grandchild, LW-Legal Ward).
7. **Student Status** – Indicate your dependent's student status if age 19 or older for 2006 (Y=Yes has student status, N=No, does not have student status).
8. **Selected Physician** - Indicate the *first and last name and county* of your primary physician. If available, list your physician's *provider number*. Write **none** if you have chosen the Standard Plan.
9. **Sign and date** - Make sure you sign and date your application.
10. Send your application to:  

Employee Trust Funds  
P. O. Box 7931  
Madison, WI 53707-7931
11. **Your application must be postmarked by the last day of the Dual-Choice Enrollment period (October 28, 2006). LATE APPLICATIONS WILL NOT BE ACCEPTED.**