Print Form

ETF Use Only

State of Wisconsin
Department of Employee Trust Funds

HEALTH INSURANCE APPLICATION/CHANGE FORM

Employer Notes

1. APPLICANT INFORMATION

Applicant – Last Name	First	Middle	Previous Name	Social Security Number

Address—Street and No.	City	State	Zip Code

County	Country (if not USA)	Home Telephone No.	Daytime Telephone No.
		( )	( )

MARITAL STATUS: ☐ Single ☐ Divorced *(date)* _____ ☐ Married *(date)* _____ ☐ Widowed *(date)* _____

ELIGIBILITY STATUS (check one)
☐ Employee ☐ Survivor ☐ Continuant (COBRA) ☐ Annuitant

I WANT MY COVERAGE TO BE EFFECTIVE:
☐ As soon as possible ☐ When employer contributes premium

COVERAGE DESIRED ☐ Single ☐ Family

HEALTH PLAN SELECTED _____

2. REASON FOR APPLICATION

A. Check all boxes that apply. Go to Section 3.

☐ Initial Enrollment – 02
☐ Moved from Service Area – 41 Date:_____
☐ Change to Family Coverage – 43
☐ Change to Single Coverage – 44 or 45
☐ Spouse to Spouse Transfer - 31
Spouse's State Agency_____
☐ Physician or Clinic Change (completed Section 3)
☐ Transfer from One State Agency to Another – 04
Name of previous State Agency_____
☐ COBRA (or continuation) – 63
☐ Dual-Choice – 40 Current Health Plan _____
☐ Other:_____

B. Check all boxes that apply. Complete event date.

Event Date: _____
☐ Cancellation – 09
☐ Name Change, former name_____
☐ Address Change (indicate in Section 1)
☐ Telephone Number Change (indicate in Section 1)
☐ Social Security Number Correction to_____
for (name)_____
☐ Update Other Insurance Coverage (complete Section 6)

C. Complete the following for **deleting** a dependent. List only dependents affected by this change below.

Reason: ☐ Divorce ☐ Age** ☐ Dependent Married ☐ Student Status Changed ☐ Other _____

***Dependent turned 19 and is not a full-time student; full-time student turned 25; grandchild of a dependent that turned 18.*

Last Name	First	Middle	Birthdate Mo	Birthdate Day	Birthdate Yr	Gender M/F	Social Security Number	Event Date	Dependent's Address (if different than subscriber's)

NOTE: THE DELETION OF A DEPENDENT DUE TO LOSS OF ELIGIBILITY PROVIDES AN OPPORTUNITY FOR CONTINUATION COVERAGE (COBRA) UP TO 36 MONTHS PROVIDED NOTICE IS GIVEN TO THE EMPLOYER WITHIN 60 DAYS OF EVENT

D. Complete the following when **adding** a dependent. List only dependents affected by this change in Section 3.

Reason: ☐ Marriage ☐ Student Status Changed ☐ Birth ☐ Legal Ward* ☐ Adoption*
☐ Disabled ☐ Other _____ Event Date _____

**Please attach documentation for additions due to legal ward or adoption status*

Dependents include spouse and unmarried children. Children include those who are dependent upon you and/or the other parent for at least 50% of their support, meet the support tests as a dependent for federal income tax purposes and are your natural children, legal wards who become your permanent ward prior to age 19, adopted children, stepchildren, or children of your dependent child until your child reaches age 18.

(Continued on reverse side.)

Applicant Name	Social Security Number

3. ENROLLMENT INFORMATION

Last Name First Middle Previous	Birthdate Mo	Day	Yr	Gender (M/F)	Social Security Number	Rel. Code	Student Status	Selected Physician, Clinic, or WPS Patient Choice 1 or 2 Care System	10-digit National Provider Identifier (NPI) (if available)
Applicant									
Spouse									
Dependent Children									

4. ADDITIONAL INFORMATION

a. Are you or any family member listed above currently disabled? ☐ Yes ☐ No If yes, name(s)_____

b. Are the dependent children listed above married? ☐ Yes ☐ No If yes, name(s)_____

c. Are any of the dependents listed above your grandchild? ☐ Yes ☐ No If yes, name of parent _____

5. MEDICARE INFORMATION

Are you or a family member insured under Medicare? ☐ Yes ☐ No If yes, list names of insured and Medicare dates.

Name: _____ Dates: Part A_____ Part B_____ HIC #_____

Name: _____ Dates: Part A_____ Part B_____ HIC #_____

6. OTHER COVERAGE

a. Other health insurance coverage? ☐ Yes ☐ No If yes, name of other Insurance Company _____

Name(s) of Insured(s) _____

b. Is your spouse a State of Wisconsin employee (including University of Wisconsin)? ☐ Yes ☐ No

7. SIGNATURE (read the **Terms and Conditions** on the attached page, check one box and sign)

☐ I apply for the insurance under the indicated health insurance contract made available to me through the State of Wisconsin and have read and agree to the **TERMS AND CONDITIONS**. A copy of this application is to be considered as valid as the original.

☐ I do not wish to enroll at this time.

☐ I wish to cancel my current coverage.

To the best of my knowledge, all statements and answers in this application are complete and true. All information is furnished under penalty of Wis. Stat. § 943.395.

SIGN HERE & Return to Employer ➡	Date Signed (MM/DD/CCYY)	Applicant Signature

8. EMPLOYER COMPLETES (Coding Instructions are in the *Employer Health Insurance Administration Manual*)

Employer Number	Name of Employer	Program Option Code	Surcharge Code
69-036-			

Group Number	Enrollment Type	Employee Type	Coverage Type Code	Carrier Suffix	Standard Plan Waiting Period	Participant County Code

Previous Service – Complete Information

1. Did employee participate under WRS prior to being hired by you? ☐ Yes ☐ No
2. Previous service check completed? ☐ Yes ☐ No
3. Source of previous service check: ☐ Online Network for Employers(ONE) ☐ ETF

Date Application Received by Employer (MM/DD/CCYY)	Date WRS Eligible Employment Began (MM/DD/CCYY)

Monthly Employee Share	Monthly Employer Share	Event Date (MM/DD/CCYY)	Prospective Date of Coverage (MM/DD/CCYY)
$	$		

Payroll Representative Signature	Telephone ( )

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