Department of Employee Trust Funds

GROUP HEALTH INSURANCE APPLICATION/CHANGE FORM

State of Wisconsin and Wisconsin Public Employees

Wis. Stat. § 40.51

You must submit this application to your employer if you are actively employed, or to the Department of Employee Trust Funds if you are an annuitant or on continuation. Use this form when electing, declining, or canceling health insurance coverage; making changes; and adding or deleting a dependent. For complete enrollment and program information, read the booklet, **It's Your Choice**. Your initial enrollment period is as follows:

a) Within 30 days of your date of hire to be effective the first of the month on or following receipt of application by the employer; or

b) **(State employees only)** Before becoming eligible for state contribution (completion of six months of state service under the Wisconsin Retirement System, or completion of 1000 hours of service for WISCRAFT employees) This does not apply to UW unclassified faculty/academic staff,
Note: Effective July 1, 2008, the eligibility period for receipt of the state contribution toward health insurance premiums is reduced from six months of state service to two months of state service. This change does not include state limited term employees who will be required to complete six months of state service under the WRS before becoming eligible for state contribution.

c) **(Wisconsin Public Employers' participants only)** Within 30 days prior to becoming eligible for employer contribution.

If you choose to enroll within your initial enrollment period, we recommend that you submit this application to your employer immediately upon employment. For complete Initial Enrollment information, please read the section entitled "Initial Enrollment" in the **It's Your Choice** booklet. If you missed your enrollment opportunity there may be other enrollment periods available to enroll without limitations or waiting periods. For complete enrollment and program information, read the booklet, **It's Your Choice**.

There are no interim effective dates, except as required by Federal HIPAA law. If your application is submitted after these enrollment periods, you will be subject to waiting periods as described in the **It's Your Choice** booklet.

INSTRUCTIONS FOR COMPLETING HEALTH INSURANCE APPLICATION/CHANGE FORM

SECTION 1 – APPLICANT INFORMATION

1. *Print* your responses *clearly* and *legibly*.
2. Enter your complete name (including your previous name, if applicable), your Social Security Number, your home address, including the county, and your home and daytime telephone numbers in the spaces provided.

NOTE: If you choose not to enroll, go to Section 7.

3. Marital Status: Check the box which applies to you. If you have indicated that you are Widowed, Divorced, or Married, list the date in the space provided.
4. Eligibility Status: Check one box which describes your status as an applicant.
5. For initial enrollment only, indicate if you want immediate health insurance coverage, or coverage when you become eligible for the employer contribution toward the health insurance premium.
6. Coverage Desired: Indicate the level of coverage desired by checking either single or family.
7. Health Plan Selected: Indicate the name of the Health Plan that you want to provide your health insurance.

SECTION 2 – REASON FOR APPLICATION

Subsections A and B

1. Indicate the reason for submitting this application by checking the box(es) that apply.
2. If checking boxes in Subsection A only or both A and B, go to Section 3 and complete all enrollment information.
3. If checking boxes in Subsection B only, go to Section 7 to complete the application except, if you are updating Other Insurance Coverage complete Section 6 & 7.

Changes To Dependent Coverage

Subsection C

Complete this Subsection when deleting a dependent. Check the reason and list all dependents to be deleted from your Health Insurance Contract. Go to Section 7 to complete the application.

Subsection D

Complete this Subsection when adding a dependent. Check the reason for adding a dependent(s) and indicate the event date. Go to Section 3 and list all family members who are being added to your Health Insurance Contract. Also, complete Sections 4, 5, 6 and 7.

SECTION 3 – ENROLLMENT INFORMATION

Provide all information requested in this Section for yourself, when applying for single coverage; when applying for family coverage, list yourself and all eligible dependents. If the social security number is not known because it was just applied for, write "APPLIED FOR" in that field. For "Rel. Code," use the following codes to describe the relationship of dependents to you:

01=Spouse	19=Child
15=Legal Ward	24=Dependent of a Minor
17=Stepchild	

Completion of the Student Status column is required only if the dependent child(ren) are between the ages of 19 and 25. F=Full-Time, P=Part-Time, and N=Not a Student.

For yourself and all eligible dependents, provide the name of the physician or clinic, or if you are selecting WPS Patient Choice Plan 1 or WPS Patient Choice Plan 2, indicate a care system. If you have selected the Standard Plan, please indicate none.

If available in the Provider Directory published by the health plan you have selected, indicate the 10-digit National Provider Identifier (NPI) for the selected providers.

SECTION 4 – ADDITIONAL INFORMATION

Indicate "Yes" or "No" for all three questions, and list names as applicable.

SECTION 5 – MEDICARE INFORMATION

Indicate whether or not you or any of your dependents (including your spouse) are covered by Medicare, and list the names of those covered. Provide the Health Insurance Claim number (HIC#) and effective date from the Medicare card for any individuals covered by Medicare.

SECTION 6 – "OTHER COVERAGE"

Provide information regarding any concurrent group *health insurance* under which you or your dependents (including your spouse) are covered.

NOTE: "Other coverage" does not include supplemental insurance (for example, EPIC, DentalBlue).

SECTION 7 – SIGNATURE

Read the **TERMS AND CONDITIONS** on the reverse side of this page.

1. If applying for health insurance coverage, check the box that you are applying for coverage, sign and date the application indicating that you have read and agree to the terms and conditions as indicated. Submit the application to your payroll representative, or if an annuitant/continuant to ETF.
2. If declining health insurance coverage, check the appropriate box that you do not wish to enroll, sign and date the application, and submit to your payroll representative.
3. Your employer will complete Section 8 and provide a copy of the application to you. For annuitants/continuants, ETF will complete section 8 and provide a copy of the application to you.

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	Day	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
	( )

COPY AND DISTRIBUTE: ☐ **ETF ADVANCE** ☐ **CARRIER ADVANCE** ☐ **ETF COVERAGE REPORT** ☐ **EMPLOYEE** ☐ **EMPLOYER**

HEALTH INSURANCE APPLICATION/CHANGE FORM
TERMS AND CONDITIONS

1. To the best of my knowledge, all statements and answers in this application are complete and true. I understand that if I provide false or fraudulent information on this application, I may face criminal charges/sanctions under Wis. Stat. § 943.395.

2. I authorize the Department of Employee Trust Funds (ETF) to obtain any information from any source necessary to administer this insurance.

3. I agree to pay in advance the current premium for this insurance and I authorize my employer (the remitting agent) to deduct from my wages or salary an amount sufficient to provide for regular premium payments that are not otherwise contributed. The remitting agent shall send the premium on my behalf to ETF.

4. I understand that eligibility for benefits may be conditioned upon my willingness to provide written authorization permitting my health plan and/or ETF to obtain medical records from health care providers who have treated me, my spouse or any dependents. If medical records are needed, my health plan and/or ETF will provide me with an authorization form.

5. Any children, as defined, listed on this application are unmarried and dependent on me, or the other parent, for at least 50% of support and maintenance. Provided these conditions are met, children may be covered through the end of the year in which they turn 19; or if they are full-time students, coverage continues through the end of the year in which they cease to be a full-time student or turn age 25. Children may also be covered beyond age 19 if they have a disability of long standing duration and are incapable of self-support.

6. I understand it is my responsibility to notify the employer, or if I am an annuitant or continuant to notify ETF, if there is a change affecting my coverage, including but not limited to, a change in eligibility due to divorce or marriage, or an address change due to a residential move. Furthermore, failure to provide timely notice may result in loss of coverage, delay in payment of claims and/or loss of continuation rights. Upon request, I agree to provide any documentation that ETF deems necessary to substantiate my eligibility or that of my dependents.

7. I understand that if there is a qualifying event in which a qualified beneficiary (me, my spouse or any dependents) ceases to be covered under this program, the beneficiary(ies) may elect to continue group coverage as permitted by state or federal law for a maximum of 36 months from the date of the qualifying event or the date of the notice to my employer, whichever is later. I also understand that if continuation coverage is elected by the affected qualified beneficiary and there is a second qualifying event (i.e, loss of eligibility for coverage due to death, divorce, marriage but not including non-payment of premium) or a change in disability status as determined by the Social Security Administration, continuation coverage, if elected subsequent to the second qualifying event, will not extend beyond the maximum of the initial 36 months of continuation coverage. I understand that notification of these events must be made to ETF in order to take advantage of the maximum 36 months.

8. I agree to abide by the terms of my benefit plan, as explained in any written materials I receive from ETF or my health plan, including, without limitation, the ***It's Your Choice*** booklet.