

DECLARATION OF EMPLOYER STATUS

Complete this form only if you are the owner of a company/business and you wish to pay for your own individual health insurance policy using your company/business check.

Applicant Name: _____

Applicant Address: _____

Applicant Daytime Phone Number: _____

Company/Business Name: _____

I am the person named above as Applicant, and by signing this document I understand and agree to the following:

1. I am an owner of a company/business, and I desire to use the check stock of such company/business in order to pay for my own individual health insurance policy through Wisconsin Physicians Service Insurance Corporation ("WPS") or WPS Health Plan, Inc. ("Arise");
2. If I have employees besides myself employed through my company/business, my company/business does not directly nor indirectly pay for all or any portion of an individual or group health insurance premium for my employees;
3. If I have employees besides myself employed through my company/business, my company/business does not collect nor participate in the collection of any portion of an individual or group health insurance premium for my employees;
4. My company/business does not treat any individual or group health insurance policy as part of a plan or program under Section 162, Section 125, or Section 106 of the United States Internal Revenue Code; and
5. I agree that should I, in the future, decide to offer a health insurance plan through WPS or Arise to the employees of my company/business, I will no longer be allowed to pay for my own individual health insurance policy using the check stock of my company/business unless I am not eligible for health insurance coverage under that group insurance plan.

Applicant Signature Date

Agent Signature as Witness Date

Return completed form to:

Fax: 608-223-3639

Email: Billing@wpsic.com

Mail : P.O. Box 11625
Green Bay, WI 54307-1625

