INDIVIDUAL POLICY CHANGE APPLICATION

Instructions: Please complete all applicable areas of this application. Please print using **black** ink. WPS/Delta Dental of Wisconsin/WPS Health Plan, Inc. d/b/a Arise Health Plan ("Insurer") does NOT guarantee approval of this application for any person, or issuance of a policy. If you do not understand any questions on this application, please contact your agent or Individual Sales Representative. When complete, please mail this application to the appropriate company shown on Page 5.

Note: Only complete this change application if you are making a change to your current policy. If you would like to apply for the currently marketed plan, please complete the Individual Application.

Customer Name _____

Customer Number_____ Social Security Number _____

Are you a WPS Health Insurance or Arise Health Plan member? ◯ **WPS** ◯ **ARISE**

1. Information Changes

A. CHANGE NAME

From: _____
Last First Middle Initial

To: _____
Last First Middle Initial

Effective Date of Change: _____ (Check one:) ◯ Primary Applicant ◯ Spouse ◯ Dependent Child

B. CHANGE ADDRESS

Current Address: _____
Number and Street City County State ZIP

New Address: _____
Number and Street City County State ZIP

Effective Date of Change: _____ New Phone Number (if applicable): _____

If you have moved to a different county, your network and rates, if applicable, may be affected.
Please contact your agent or Sales Representative.

C. Change Benefits – For benefit options please see page 2.

1. Dental Change:

◯ Add Delta Dental Plan underwritten by Delta Dental of Wisconsin – dental coverage is only available if you have selected medical coverage.
If any person applying for coverage has other dental coverage that is not canceling and will not be replaced, you are not eligible for the dental plan coverage.

◯ Cancel Dental Plan.

2. Primary Care Practitioner (PCP) Change - Arise Health Plan Only (Or call toll free 800-332-6249)

_____

_____

D. Types of Coverage and Benefits Plan - Please refer to your policy for any non-participating provider benefits. Please choose a plan offered by the Insurer you are currently enrolled with. To change between Insurers, please complete the Individual Application.

Arise & WPS Plans – Deductibles and out-of-pocket maximums listed below are for individuals. Family deductibles and out-of-pocket maximum are two times the individual. Please see summary of benefits and coverage for more detailed policy benefits.

Selection	Metal Tier	Deductible	Coinsurance (amount you pay)	Out-of-Pocket Limit	Convenient Care Clinic	PCP	Specialist	Prescription Plan Preventive/Preferred Generic/Non-Preferred Generic/Preferred Brand/Non-Preferred Brand/Specialty
◯ Arise HMO	Bronze	$4,500	20%	$7,350	D/C	D/C	D/C	$0 preventive, D/C all others
◯ Arise HMO ◯ Arise POS	Bronze	$7,350	0%	$7,350	D/C	D/C	D/C	$0 preventive, D/C all others
◯ Arise HMO HDHP ◯ Arise POS HDHP	Bronze	$5,500	20%	$6,650	D/C	D/C	D/C	$0 preventive, D/C all others
◯ Arise HMO HDHP	Bronze	$6,650	0%	$6,650	D/C	D/C	D/C	$0 preventive, D/C all others
◯ Arise HMO	Catastrophic *	$7,350	0%	$7,350	D/C	D/C	D/C	$0 preventive, D/C all others
The above Arise plans are available in the following counties: Brown, Calumet, Dodge, Door, Fond du Lac, Green Lake, Kewaunee, Manitowoc, Marinette, Marquette, Oconto, Outagamie, Ozaukee, Sheboygan, Washington, Waukesha, Waupaca, Waushara and Winnebago								
◯ WPS PPO	Bronze	$4,500	20%	$7,350	D/C	D/C	D/C	$0 preventive, D/C all others
◯ WPS PPO	Bronze	$7,350	0%	$7,350	D/C	D/C	D/C	$0 preventive, D/C all others
◯ WPS PPO HDHP	Bronze	$5,500	20%	$6,650	D/C	D/C	D/C	$0 preventive, D/C all others
◯ WPS PPO HDHP	Bronze	$6,650	0%	$6,650	D/C	D/C	D/C	$0 preventive, D/C all others
◯ WPS PPO	**Catastrophic ***	$7,350	0%	$7,350	D/C	D/C	D/C	$0 preventive, D/C all others
The above WPS plans are available in the following counties: Barron, Bayfield, Buffalo, Burnett, Douglas, Dunn, Eau Claire, Jackson, La Crosse, Monroe, Pepin, Pierce, Polk, Rusk, Sawyer, St. Croix, Trempealeau and Washburn								

D/C = Deductible and Coinsurance PCP = Primary Care Practitioner

*** Eligibility limited to persons under age 30 or those with a hardship exemption from the Federally Facilitated Marketplace.**

E. ADDING DEPENDENT TO NEW OR EXISTING FAMILY COVERAGE

Type of Coverage Change:

◯ Single to Family ◯ Add dependent to existing family ◯ Family to Single

☐ Adding Newborn Child Newborn's Name _____ Date of Birth _____
Last First Middle Initial

Gender _____ Social Security Number _____

☐ Adding Adopted Child Child's Name _____ Date of Adoption _____
Last First Middle Initial

Date of Birth _____ Social Security Number _____ Gender _____

☐ Adding Dependent Child Child's Name _____ Date of Birth _____
Last First Middle Initial

Gender Social Security Number _____

Relationship to you _____

☐ Adding Spouse Spouse's Name _____
Last First Middle Initial

Spouse's Social Security Number _____ Date of Marriage _____

Date of Birth _____ Gender _____

Within the past six months, has anyone named above who is age 18 or over used tobacco regularly (four or more times per week on average?) ○ Yes ○ No

If yes, please indicate which applicants: _____

F. TERMINATING A DEPENDENT'S COVERAGE

Dependent Name _____ Date of Birth _____

Relationship to You _____ Type of Coverage Being Terminated _____

Date of Coverage Termination _____

Reason for Coverage Termination _____

G. REASON FOR CHANGE

Is the requested change due to a qualifying event? ○ No ○ Yes

If yes, choose:

- ○ Involuntary loss of Minimum Essential Coverage for any reason other than fraud, intentional misrepresentation of a material fact or failure to pay premium
- ○ Was previous coverage under COBRA? ○ Yes ○ No
  If yes, please indicate your COBRA start date: _____
- ○ Marriage ☐ Birth ☐ Adoption or placement for adoption or appointment of guardianship
- ○ Other _____

Please provide the date of the qualifying event _____

H. INFORMATION ON OTHER COVERAGE

Please provide the following information for any person named on this application who has other individual or group health coverage:

Name	Current Health Carrier	Policy or Group# Effective Date:	Will coverage terminate upon approval of this policy? ○ Yes ○ No Termination Date:
Name	Current Health Carrier	Policy or Group# Effective Date:	Will coverage terminate upon approval of this policy? ○ Yes ○ No Termination Date:

Is anyone named on this application eligible for Medicare? ○ No ○ Yes

If yes, please indicate who: _____

*Please note, anyone named on this application who is enrolled in Medicare will not be covered by this policy.

I. OTHER CHANGE

If a requested change is other than a change listed is Subsection A. through H. above, please explain below.

_____

_____

_____

2. Policy Effective Date *(if this application is approved by the Insurer, the policy effective date is determined only by the Insurer)*

Please indicate your requested effective date. Please note, the effective date can be no later than 60 days from the date of application.

_____ / _____ / _____

The Policy Effective Date will be determined by the Insurer, subject to any applicable law or policy provisions.

3. CHANGE PREMIUM PAYMENT OPTION *(Business checks and/or accounts cannot be used for premium payment)*

Change to:

◯ **AUTOMATIC WITHDRAWAL.** We electronically transfer your premium directly from your bank account. (If you select this option, please complete the Payment Authorization Form.)
With this option your premium payment can be drafted from your bank account.

◯ **DIRECT BILL.** We send a premium notice directly to your home. You return payment to the Insurer by the premium due date.

◯ **CREDIT/DEBIT CARD.** If you are applying for Arise Health Plan, please visit https://pay.arisehealthplan.com. If you are applying for WPS, please visit https://pay.wpsic.com.

4. Certification/Understanding Notice

CERTIFICATION: I represent and certify all of the following: no answer or information written by myself in this application was provided by the agent or anyone else (except for information provided by other family members); such representations are true, accurate, and complete to the best of my knowledge.

UNDERSTANDING: I understand: the representations I make, together with any supplemental representations that I make, shall be the basis for the Insurer to issue any coverage; that no agent has the authority to waive an answer to any question, pass on insurability, make or alter any contract, or waive or alter any of the Insurer's other rights or requirements; that no coverage will be effective unless and until the date specified by the Insurer after this application has been approved by the Insurer; any misrepresentation contained herein may be used to reduce or deny a claim, or to rescind and void coverage and the policy within the contestable period, if such misrepresentation materially affects the Insurer's acceptance of the risk, including approving any person for coverage.

I understand that the Insurer has no liability for anything the agent 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 the agent in response to questions asked by myself, my spouse or my dependent(s). Furthermore, I understand that the Insurer is not liable for any statement, representation, or other information provided to myself, my spouse or my dependent(s) that isn't expressly contained in a written document provided to them and signed by an authorized officer of the Insurer.

I understand that the insurer fully complies with the regulations and orders regarding doing business with foreign countries or foreign nationals listed on the Office of Foreign Assets Control's Specially Designated Nationals and Blocked Persons (SDN) list. Therefore, the Insurer may rescind and void any coverage if it determines that you, your spouse or any named dependent are either listed on the SDN list or associated with an entity listed on the SDN list.

I understand and acknowledge that any person who, with intent to defraud or knowledge that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false and deceptive statement is committing a fraudulent act, which is a crime. I further understand and acknowledge that in some states, any person who, for the purpose of misleading an insurer or other person, conceals significant information from an application or claim is committing a fraudulent act.

To the best of my knowledge and belief, I represent that all statements and answers I made in this application, and on the attached sheet(s), if any, are complete and true. I have read and understand this application, including the Certification/Understanding section above.

Applicant signature:_____ Date:_____

5. Agent Statement

Did an agent or sales representative assist you in the completion of this application? ◯ Yes ◯ No
If yes, agent must complete the following:

I asked the applicant, spouse and all child(ren) over age 18 all questions contained in this application and recorded their answers exactly as given to me. I also represent that no other person provided any of their answers, or influenced any of their answers; if any of their answers were influenced by another person, I have attached a written explanation thereof to this application.

Writing Agent's Name (Print)_____ Agent's Phone #_____

Address _____ Agent's Fax # _____

City _____ State/ZIP _____ Agency Name _____

Writing Agent's License #_____ Agency's 9 Digit ID #_____

Writing Agent's Signature _____ Date Signed by Agent _____ / _____ / _____

For contact information, please see below.

Mail to: WPS Health Insurance P.O. Box 21341 Eagan, MN 55121	**Mail to:** Arise Health Plan P.O. Box 21341 Eagan, MN 55121
Call: 800-332-6421	**Call:** 800-332-6249
Visit: wpsic.com	**Visit:** arisehealthplan.com

6. Internal Use Only-Notes