EMPLOYER GROUP ENROLLMENT APPLICATION

WPS A HEALTH SOLUTIONS COMPANY

DELTA DENTAL

For internal use only

INSTRUCTIONS: Please complete the entire application. Please print using **black** ink. Wisconsin Physicians Service Insurance Corporation/Delta Dental of Wisconsin, ("Insurer") or Third-Party Administrator ("TPA") does NOT guarantee approval of this application for any person, or issuance of a policy.

Section 1—Employer Demographics

Type of Application: ☐ New Group ☐ Change to Existing Group Number:_____		Requested Effective Date:_____ Requested Anniversary Date:_____		
Employer Legal Name	Form 5500 Plan Number (If applicable)	SIC Code (nature of business)	Federal Tax ID Number (EIN)	
Location/Street Address of Business	City	State	ZIP Code	County
Billing Address	City	State	ZIP Code	County
Name of Contact Person	Title of Contact Person	Telephone Number		
Email Address				
Nature of Business		Type of Business (e.g., LLC)		
Name of Subsidiary(ies)/Affiliate(s)		Federal Tax ID Number (if different)		
Address	City	State	ZIP Code	County

Section 2—Eligibility

A. Total Number of Employees: _____ Include all employees (full-time, part-time, and seasonal).
All full-time sole proprietors, corporate officers, directors, and employees are eligible for coverage. Retirees, part-time, temporary, and seasonal employees are not eligible for coverage. Exceptions are subject to the Insurer's Underwriting requirements and guidelines.

B. Actively at Work Requirement:
2–50 Total Employees: 30 hours per week
51 or More Total Employees: _____ hours per week (not to exceed 30 hours per week)

C. Are domestic partners and their eligible dependents eligible for coverage? ☐ Yes ☐ No
This question C. does not apply to local government units per Wis. Stat. 66.0137(1)(ae).

D. Are any classes of eligible employees to be excluded from any coverage? ☐ Yes ☐ No
If yes, please explain and identify each coverage: _____

E. Are any employees or dependents currently on or eligible for COBRA or State Continuation? ☐ Yes ☐ No
If yes, please list name, effective date, and termination date: _____
_____

F. To the best of your knowledge and belief, is any employee or dependent (including spouse) proposed for coverage disabled, unable to work, or not at work because of a current or approaching hospital confinement, leave of absence, or otherwise incapacitated? ☐ Yes ☐ No

If yes, please provide each person's name and status: _____
_____

G. Is each coverage applied for subject to or part of a union-negotiated collective bargaining agreement? ☐ Yes ☐ No
If yes, when does that agreement expire? _____

H. Requested Probationary Period:
- ☐ 0 days (Only groups with 51 or more total employees may select this option)
- ☐ First day of the calendar month following one month of full-time employment
- ☐ First day of the calendar month following two months of full-time employment
- ☐ The day following 90 days of full-time employment
- ☐ Other (Only groups with 51 or more total employees may select this option):_____

Does the same probationary period apply to all covered classes? ☐ Yes ☐ No (***Only groups with 51 or more total employees may select this 'No' option***)
If No, specify: _____

I. Requested Employee Termination Date (optional only for groups with 51 or more total employees)
- ☐ The last day of the calendar month (standard, including groups with < 51 employees)
- ☐ The day the employee's employment terminates, standard for all other reasons
- ☐ Immediately for all termination reasons

Section 3—Plan Information

A. Annual Open Enrollment:
2–50 Total Employees: Month prior to renewal date
51 or More Total Employees:
- ☐ Month prior to renewal date
- ☐ Other: Dates for open enrollment (***end date must be before renewal date***)

From: _____ To: _____

B. What percentage of the monthly premium is to be paid by the employer for each of the following:
(Minimum Employer Contribution is 50% of the employee premium)

_____ % Employee Only Coverage _____% Limited Family Coverage _____% Family Coverage

C. The applicable benefit options (deductible, coinsurance, annual out-of-pocket limits, preferred/participating provider networks, etc.) are the coverage and corresponding benefit options stated in the final, written quote that was issued by the Insurer and signed by the employer's representative in Section 7 below. If the Insurer approves this application, the actual benefit options for this employer's group medical coverage will be contained in the Certificate of Coverage, which is part of the group master policy issued by the Insurer to the employer as the group policyholder.

D. For groups of **100** or more enrolled employees, the following additional classes are eligible for coverage:

☐ Retirees ☐ Part-time employees

E. Other special requests/comments:

_____
_____

Section 4—Information About Your Current Plan

A. Will/does your company offer other group health coverage?..... ☐ Yes ☐ No

B. Are you replacing existing group health insurance?..... ☐ Yes ☐ No
Name of current insurance carrier/administrator _____

Original effective date _____

C. What is the name of your current workers' compensation carrier?_____

Section 5—Change Information

A. Employer Name Change
Employer's Former Name: _____
Employer's New Name: _____

B. Employer Address Change
Employer's Former Address: _____
Employer's New Address: _____

C. Employer Coverage Change
Employer's Old Coverage: _____
_____
Employer's New Coverage: _____
_____

D. Change probationary period from _____ to _____

E. Other Change (Please explain): _____
_____
_____

Section 6—Premium/Billing Information

A check for $_____ made payable to the Insurer is being submitted with this application as payment by this employer to be applied toward the initial month's premium if this application is approved by the Insurer and the group master policy is issued. The monthly premium billed by the Insurer will be due and payable to the Insurer on the first day of the coverage month.

Group Billing Options:

☐ **Automatic Withdrawal.** We electronically transfer your premium directly from your bank account on the first business day of the coverage month. If the first business day of the month falls on a weekend or holiday, we will withdraw the funds on the next business day. Please complete Section 10—Authorization Agreement for Electronic Fund Transfers.

☐ **Direct Bill.** We send a premium notice directly to your billing address monthly. You return payment to the Insurer by the first business day of the coverage month.

Section 7—Employer Statement/Certification

The group medical coverage is guaranteed renewable. However, your group medical coverage could be canceled if the Insurer terminates all of the group medical insurance policies for this group class, or if you: fail to timely pay your monthly premium; engage in fraud or misrepresentation; breach the Insurer's group insurance policy; fail to meet minimum participation requirements; or become ineligible as a group due to: (a) ceasing active business operation; (b) losing status as a legal entity; or (c) moving the business to a state where this type of group medical insurance policy is not offered by the Insurer.

The Insurer may investigate the information on this application. Any findings may be used to deny coverage for one or more employees of the group or the entire group. Please indicate the name, title, and telephone number of an employee in your company who can provide necessary clarification of the employee and group information provided on this application.

Name: _____ Title: _____

Phone Number: _____

I hereby certify that all information recorded in this application is true and complete to the best of my knowledge. I have been advised not to terminate all existing coverage, whether on an insured or self-funded basis, unless and until the Insurer notifies me in writing that coverage has been approved and the agent represents the employer, not the Insurer.

I understand that the Insurer will rely, in part, on the information provided in this application to issue or deny coverage. If the Insurer approves this application, I understand coverage will become effective on the date assigned by the Insurer and no coverage will be in force until that date.

I understand no agent or other person has the authority to alter, bind the Insurer, or waive or change any terms, conditions, and/or provisions of the policy or any other requirement imposed by the Insurer. I understand the employer represents its employees and their dependents, not the Insurer. As the employer's authorized representative and acting on that employer's behalf, I understand, agree with, and approve each and every certification made by the agent in Section 9—Agent Certification of this application.

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 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.

If this application is approved, I understand that the Insurer will not be, and are not, a plan sponsor, plan administrator, or fiduciary for any purpose under the Employee Retirement Income Security Act (ERISA) of 1974, as amended, or under any state or federal law. I understand the employer is solely responsible for carrying out any obligation created, required, or imposed by ERISA or any other law, as it may apply to such group insurance policies.

Signature of Employer Representative: _____

Signed at: _____ Date: _____
City State

Section 8—Issue Information

The group master policy will be sent directly to the Employer. Identification cards will be mailed directly to each covered employee with instructions on accessing the online member guide.

Important! *DID YOU REMEMBER TO INCLUDE:*

- ☐ A copy of the Insurer's quote.
- ☐ Completed and signed Employee(s) Group Enrollment Application for each eligible employee, both enrolling and waived, if applicable.
- ☐ A copy of the group's most recent State Quarterly Wage and Tax Report (groups with more than 100 total employees should include a census of all full- and part-time employees).
- ☐ Completed Delta Dental Group Application if dental coverage is requested.
- ☐ Rating and Renewability Disclosure Form.

Section 9—Agent Certification

I hereby certify and represent all of the following as being true: I asked all questions accurately and fully recorded all information given by the Employer Representative in this application; I advised the Employer Representative not to terminate existing coverage unless and until the Insurer notifies him/her, in writing, that this application has been approved; I used only advertising approved by the Insurer to solicit this application; I told the Employer Representative nothing inconsistent with, or contrary to, the approved advertising about the benefits, group policy, and/or coverage; I didn't guarantee the Insurer's approval of this application or the Insurer's issuance of coverage; and I made no false, misleading, or deceptive statements or representations and complied with all applicable insurance laws, underwriting requirements, and marketing/sales standards maintained by the Insurer.

I hereby certify and represent all of the following as being true: I told the Employer Representative that the Insurer has no liability for anything I 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 me in response to questions asked by that Representative or anyone else; I told the Employer Representative that the Insurer is not

liable for any statement, representation, or other information provided to that Representative or anyone else that is not expressly contained in a written document provided to them and signed by an authorized officer of the Insurer; I understand that I am liable for my acts and omissions to the extent provided by law; and I understand I have no authority to alter this application, bind the Insurer by making promises and/or representations, or to waive or change the terms, conditions, and/or provisions of the group insurance policy or any requirement imposed by the Insurer.

Writing Agent's Name (Print) _____ Writing Agent's License Number _____

Writing Agent's Signature _____ Date _____

Agency Name _____ Agency Telephone Number _____

Address _____ Agency Email Address_____

City _____ State/ZIP _____ Agency Tax ID Number _____

Section 10—Authorization Agreement for Electronic Fund Transfers

Group's Legal Name _____ Group Number _____

I hereby authorize the Insurer, hereinafter called COMPANY, to initiate, if necessary, debit entries and adjustments for any credit entries in error to my: ☐ Checking Account ☐ Savings Account (select one) indicated below and the depository named below, hereinafter called DEPOSITORY, to credit and/or debit the same to such account.

Depository Name _____ Branch _____

City _____ State _____ ZIP _____

Transit Number _____ Account Number _____

This authority is to remain in force and effect until COMPANY has received written notification from me of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on said notice of termination.

Signature of Employer Representative _____ Date _____

Name and Title of Employer Representative (Please print) _____

Telephone Number _____ Fax Number _____