EMPLOYEE GROUP ENROLLMENT APPLICATION

WPS HEALTH INSURANCE

For Internal Use Only

Wisconsin Physicians Service Insurance Corporation ("WPS"), the Third-Party Administrator ("TPA"), does NOT guarantee approval of this application for any person. When complete, please mail this application to the address shown on page 4.

Section 1—Employer Information *(to be filled out by employer)*

Employer Name			
Group Number	Subgroup	Class	Department

Section 2—Employee Information

First Name		Middle Initial		Last Name	
Mailing Address			Apartment or Suite Number		Social Security Number
City		State		ZIP code	
Daytime Phone Number		Email Address		Date of Birth	

Gender	Marital Status	Employee Start Date	Hours Worked Per Week
☐ Male ☐ Female	☐ Single ☐ Married ☐ Divorced ☐ Widowed		

Race or ethnicity:

☐ Caucasian/White ☐ African American/Black ☐ Alaskan
☐ American Indian or Native ☐ Asian ☐ Hispanic or Latino
☐ Native Hawaiian or Pacific Islander ☐ Southeast Asian
☐ Two or more races
☐ Other _____

What primary language is spoken in your home?

☐ English ☐ Albanian ☐ Arabic ☐ Chinese ☐ French ☐ German
☐ Hmong ☐ Korean ☐ Laotian ☐ Pennsylvania Dutch ☐ Polish
☐ Russian ☐ Spanish ☐ Tagalog ☐ Vietnamese
☐ Other _____

WPS is committed to supporting an eco-friendly environment. The communications you receive from us will be available on your customer portal.

Section 3—Reason for Application

☐ New Employee ☐ New Group Enrollee

☐ New Enrollee due to Annual Open Enrollment **(application must be received prior to the policyholder's anniversary date)**

☐ Special Enrollment due to: **Please provide the date of the qualifying event:** ____/____/_____

- ☐ Involuntary loss of Minimum Essential Coverage for any reason other than fraud, intentional misrepresentation of a material fact, or failure to pay premium
- ☐ Marriage/Civil Union
- ☐ Domestic Partnership Registry
- ☐ Birth
- ☐ Adoption or placement for adoption or appointment of legal guardianship
- ☐ Other: _____

☐ COBRA–Reason: _____ Start Date: _____ Termination Date: _____

☐ Add Dependent(s)

☐ Changing: _____ to _____ Effective Date: _____

☐ Change Benefit Plan–Current: _____ Change to: _____

☐ Change Network Option–Current: _____ Change to: _____

☐ Deleting Coverage (Explain): _____

☐ Other–Please indicate: _____

Section 4—Type of Coverage Requested

Type of Coverage	Applying For	Waiving/Declining Coverage For
Group Medical Coverage ☐ WPS PPO Plan ☐ WPS HDHP Plan	☐ Myself ☐ My Spouse ☐ My Domestic Partner ☐ My Dependents	☐ Myself ☐ My Spouse ☐ My Domestic Partner ☐ My Dependents

Section 5—Applicant Enrollment Information

Please complete the following for all family members who are applying for coverage. If additional space is needed, please attach a separate sheet with completed information.

Dependent Name			Sex	Social Security Number	Relationship to Applicant	Date of Birth
First		MI	☐ Male ☐ Female			
Last						
First		MI	☐ Male ☐ Female			
Last						
First		MI	☐ Male ☐ Female			
Last						
First		MI	☐ Male ☐ Female			
Last						
First		MI	☐ Male ☐ Female			
Last						

Section 6—Information Regarding Other Health Coverage and Medicare

Does any person applying for coverage currently have other individual or group health coverage? ☐ Yes ☐ No

If yes, please provide coverage information below. If additional space is needed, please attach a separate sheet with completed information.

Policyholder Information	Name, Address, and Phone Number of Insurance Company/Plan Type	Policy Number	Type of Coverage	Effective Date of Coverage
Name: _____ ☐ Employee ☐ Spouse/Domestic Partner ☐ Dependent Date of Birth: _____			☐ Single ☐ Family	
			☐ COBRA	COBRA Effective Date: COBRA Termination Date:
Name: _____ ☐ Employee ☐ Spouse/Domestic Partner ☐ Dependent Date of Birth:_____			☐ Single ☐ Family	
			☐ COBRA	COBRA Effective Date: COBRA Termination Date:

Are you or any of your family members eligible for Medicare? ☐ Yes ☐ No

If yes, please complete the following or attach a copy of your Medicare card.

Name of person covered by Medicare: _____ Medicare Card Number: _____

Is Medicare eligibility due to: ☐ Over age 65 ☐ End-Stage Renal Disease (ESRD) ☐ Total Disability

Effective Dates: Part A: _____ Part B: _____ Part C (Medicare Advantage): _____ Part D: _____

Section 7—Health Coverage Waiver

If anyone named on this application is waiving or declining any coverage, please provide his/her name and check the reason he/she is waiving/declining.

Name(s) of person(s) waiving/declining: _____

☐ I am covered or will be covered under another plan that is not sponsored by my employer.

☐ My dependents are covered or will be covered under another plan that is not sponsored by my employer.

☐ Other:_____

Waiver: I certify that I have been given the opportunity to apply for group coverage and decline to enroll as indicated on behalf of me and/or my dependents. I understand that by signing this waiver, I and/or my dependents forfeit the right to coverage.

I understand that if I am declining enrollment for myself or my dependents (including my spouse/domestic partner) because of other health coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that I request enrollment within 31 days after my coverage ends. In addition, if I have a new dependent as a result of marriage, civil union, domestic partnership registry, birth, adoption, or placement for adoption, I understand that I may be able to enroll myself and my dependents provided that I request enrollment within 31 days after the marriage, civil union, domestic partnership registry, birth, or adoption. I further understand that, other than these qualifying events, if this form is submitted after the enrollment period, I cannot enroll until the next annual enrollment period, if applicable.

_____	_____	_____
SIGNATURE OF EMPLOYEE (required if waiving coverage)	**PRINT NAME**	**DATE**

Section 8—Notice of Special Enrollment Rights for Health Coverage

If you are declining enrollment for yourself or your dependents (including your spouse/domestic partner) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose coverage (or if the employer stopped contributing toward your or your dependent's other coverage).

Loss of coverage events include, but are not limited to: (a) the person no longer lives, resides, or works within his or her HMO service area, the HMO does not provide coverage for that reason, and there is no other coverage under the plan for the individual; (b) a dependent loses dependent status because he or she attains a particular age; (c) the plan no longer offers any benefits to a class of similarly situated individuals (such as if the plan terminates coverage for all part-time workers); and (d) a benefit package option terminates or the issuer stops operating in the group market.

However, you must request enrollment within 31 days (or 60 days for Medicaid eligibility, or birth or adoption of a child) after your or your dependent's other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, civil union, domestic partnership registry, birth, adoption, or placement for adoption, you may be able to enroll yourself and other dependents. However, you must request enrollment within 31 days after the marriage, civil union, domestic partnership registry, birth, adoption, or placement for adoption.

This notice is for informational purposes only and is informing you of your special enrollment rights.

Section 9—Terms and Conditions

I hereby enroll for coverage under the insurance coverage(s) for which I am presently eligible, or for which I may become eligible. I understand and agree that the information obtained by using this Application will be used by TPA to determine eligibility for benefits. I, on behalf of myself, my spouse/domestic partner, and my dependent child(ren), if any, named herein, agree to cooperate in providing TPA with information needed to process this Application.

If any payroll deductions are required for this coverage, I authorize such deductions from my earnings. I reserve the right to revoke this deduction authorization at any time upon written notice to the employer.

An Application should not be submitted more than 45 days prior to the effective date.

I acknowledge that I have read and completed the entire Application. If I received assistance in reading or completing this Application, I have identified in the space provided below the person(s) who provided me with such assistance. I additionally agree that TPA is not liable for any statement, representation, or other information provided to me, my spouse/domestic partner, or my dependent child(ren) that is not expressly contained in a written document provided by TPA and signed by an authorized officer of the TPA. I agree that no coverage will be effective until the date specified by the employer or TPA after this application has been accepted. I also understand that if I decline any coverage, future changes in coverage are NOT automatic and may be subject to TPA's approval.

Name of Person Providing Assistance (if applicable): _____

Section 10—Acknowledgement and Signatures

I acknowledge that:

- The signatures shown below allow me and/or my spouse/domestic partner to release to TPA information about any person listed on my plan application documents.
- Under the Health Insurance Portability and Accountability Act (HIPAA), TPA, without my authorization, may only release limited information about my selection of a plan to my spouse/domestic partner, adult/minor children, producer, or anyone else.
- TPA may collect, use, or disclose the nonpublic personal information of persons listed on this application as required or permitted by law and to conduct routine business functions such as determining eligibility for enrollment, reviewing prior coverage for waiting periods, paying claims, and, if appropriate, coordinating benefits, and fulfilling other legal obligations specified in my Summary Plan Description.
- I have read and agree to the Terms and Conditions (Section 9) included with this application.

I declare that, to the best of my knowledge, all information I have provided with this application is true and complete, and that all of the persons for whom I am requesting enrollment are eligible for coverage. I understand that if I have made intentionally false or misleading statements on behalf of myself or any family members, my coverage may be canceled retroactively to its effective date. I further understand that it is a crime to knowingly provide false, incomplete, or misleading information for the purpose of fraudulently obtaining health coverage. Penalties may include imprisonment, fines, and denial of benefits.

☐ **Documentation**: I am enclosing all documentation as required, including, if applicable, documentation to enroll due to a special qualifying event. Any missing information may delay processing of my application.

☐ **Signature**: This application has been signed by me and my spouse/domestic partner, if applicable.

☐ If not the primary applicant, I am the:

- ☐ Parent
- ☐ Holder of Power of Attorney (attach legal documentation)
- ☐ Legal Guardian (attach legal documentation)

Primary Applicant (Parent/Legal Guardian) Signature: _____ Date: _____

Spouse/Domestic Partner/Dependent Signature (if applicable): _____ Date: _____

For contact information, please see below.

Mail to:

Wisconsin Physicians Service Insurance Corporation

P.O. Box 8190

Madison, WI 53708-8190

Call:

888-915-5618

Visit:

wpshealth.com

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