INDIVIDUAL TRANSITIONAL POLICY CHANGE APPLICATION

WPS A HEALTH SOLUTIONS COMPANY

DELTA DENTAL

Internal use only

Instructions: Please complete all applicable areas of this application. Please print using black ink. WPS and Delta Dental of Wisconsin ("Insurer") do 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 WPS as shown on Page 6.

Subscriber Name	Subscriber #	Effective Date of Change

1. Information Changes

A. CHANGE IN POLICYHOLDER

Is the requested change for the spouse to become the policyholder? ☐ No ☐ Yes If yes, please explain: _____

_____

_____

NOTE: If yes, sections 3-6 need to be reviewed and completed. Section 2 does NOT need to be completed.

B. CHANGE NAME

From Last Name:	First Name:	M.I.
To Last Name	First Name:	M.I.

C. CHANGE ADDRESS

Current Street Address:	City	State	County	ZIP
New Street Address:	City	State	County	ZIP

New Phone Number (if applicable):

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

D. CHANGE DENTAL BENEFITS

☐ Add Delta Dental Plan underwritten by Delta Dental of Wisconsin - dental coverage is only available if you have selected medical coverage. Requested effective date: _____

☐ 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.

☐ Terminate dental coverage. Requested termination date: _____

E. ADDING DEPENDENTS TO EXISTING COVERAGE - Section 2 NOT required for newborns.

☐ Adding Dependent Child(ren) Reason for adding child(ren): _____

Child's Last Name:	First:	M.I.:	Date of Birth:
Social Security Number:	Relationship to you:		Gender:
Child's Last Name:	First:	M.I.:	Date of Birth:
Social Security Number:	Relationship to you:		Gender:

☐ Adding Spouse—Section 2 is required

Spouse's Last Name:	First:	M.I.:	Date of Birth:
Social Security Number:	Gender:	Weight:	Height:

Within the past six months, has anyone named in this application who is age 21 or over used a tobacco product regularly, including chewing tobacco, four or more times per week on average? ☐ No ☐ Yes If yes, please indicate which applicants:_____

F. TERMINATING A DEPENDENT'S COVERAGE			
Dependent Name:			Date of Birth:
Requested Termination Date:	Reason for Coverage Termination:		

G. 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	Effective Date:	Will coverage terminate upon approval on this policy? ☐ Yes ☐ No
Name	Current Health Carrier	Effective Date:	Will coverage terminate upon approval on this policy? ☐ Yes ☐ No

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 eligible for Medicare will not be covered by this policy.

2. MEDICAL QUESTIONS

The Insurer does not use or collect genetic information for any underwriting purpose. Genetic information includes information related to genetic tests, genetic counseling, and any family history of a disease or disorder. Any such information should not be included on an application or communicated to the Insurer in any manner. For the purpose of these questions, chronic means persistent, continuous, or periodic, or a combination of any of these terms.

You are required to disclose information regarding any disease or condition for which:

- Any applicant has been diagnosed or treated by any health care provider.
- Any applicant has had testing with abnormal results.
- Any applicant is awaiting test results.
- Any applicant has been recommended or scheduled for diagnostic testing, consultation, treatment, follow-up, or surgery.
- Any applicant has taken or has been advised to take any prescription medication.
- Any change in health status for which an applicant has not sought medical care or treatment.

Within the last FIVE (5) YEARS, has anyone, including you or any family member requesting coverage, received counseling, care or treatment, medication, medical advice or been told a diagnosis for any of the following conditions or illnesses listed? (Check each box that applies.)

INFECTION AND PARASITIC DISEASES

☐ AIDS (acquired immunodeficiency syndrome), ARC (AIDS-related complex), HIV positive (the reporting of HIV test results is limited to FDA-licensed tests, and you need not report results of tests conducted at an anonymous counseling and testing site through the use of a home test kit).

☐ Lyme disease

☐ Sexually transmitted disease(s)

BLOOD, GLAND, ENDOCRINE, METABOLIC, AND IMMUNE DISORDERS (other than HIV, ARC, AIDS)

☐ Anemia/blood disorder

☐ Diabetes/high or low blood sugar. (If checked, record last HGA1C reading and date on the Additional Medical Details page.)

☐ Enlargement of lymph nodes

☐ Thyroid disease

☐ Adrenal disorder

☐ Endocrine/gland/hormone system

CANCER, CYSTS, AND TUMORS

☐ Cancer (If checked, include the stage, type and location of the tumor on the Additional Medical Details page.)

☐ Tumor, cyst, lump, polyp

MENTAL/NERVOUS/BEHAVIORAL DISORDERS

- ☐ Alcohol/chemical/drug abuse/dependency
- ☐ Has any applicant used sedatives, tranquilizers, cocaine, or other hallucinogenic or narcotic drugs?
- ☐ Eating disorders such as, but not limited to, anorexia or bulimia
- ☐ Mental/emotional condition/depression
- ☐ Autism
- ☐ Suicide attempt
- ☐ Alcohol, chemical drug abuse therapy, treatment or counseling within the last five years (if checked, record date of last session on the Additional Medical Details page)

BRAIN AND NERVOUS SYSTEM

- ☐ Brain disease or injury/concussion
- ☐ Convulsions/seizures/epilepsy
- ☐ Chronic headaches/migraines
- ☐ Neurological condition/disease/injury
- ☐ Sleep apnea/chronic sleep disorder
- ☐ Stroke
- ☐ Mutiple sclerosis
- ☐ Paralysis

SKIN DISORDERS

- ☐ Skin condition, abnormal or cancerous moles, or eczema/cysts/cancer

EYES, EARS, AND NOSE

- ☐ Chronic ear/nose condition/disease
- ☐ Cataracts/glaucoma
- ☐ Chronic eye condition/disease

MOUTH, THROAT, OR JAW

- ☐ Chronic throat/tonsil/adenoid/disease/disorder
- ☐ TMJ/jaw joint

HEART OR CIRCULATORY SYSTEM

- ☐ Blood/circulatory disorder
- ☐ Heart attack/chest pain/murmur/angina
- ☐ Elevated/high cholesterol (if checked, record last reading and the date on the Additional Medical Details page)
- ☐ Elevated/high or low blood pressure. If checked, record last three reading and dates in the past 12 months on the Additional Medical Details page.)
- ☐ Phlebitis/blood clot
- ☐ Heart disease/disorder

RESPIRATORY SYSTEM

- ☐ Asthma
- ☐ Emphysema/chronic obstructive pulmonary disease (COPD)
- ☐ Chronic respiratory/lung condition
- ☐ Pneumonia/bronchitis

DIGESTIVE SYSTEM

- ☐ Appendicitis/chronic abdominal pain
- ☐ Blood in stool
- ☐ Colon/rectum/intestine/bowel/Crohn's disease
- ☐ Ulcer/esophageal reflux
- ☐ Gallbladder
- ☐ Liver condition/hepatitis/pancreas

URINARY SYSTEM

- ☐ Bladder/urinary tract
- ☐ Kidney/kidney stones

MALE OR FEMALE REPRODUCTIVE SYSTEMS

- ☐ Breast (lumps or masses)
- ☐ Prostate/elevated PSA/prostatitis
- ☐ Reproductive system disorder/infertility/dysfunction
- ☐ Abnormal pap smear or mammography

PREGNANCY, BIRTH, OR CONGENITAL ABNORMALITIES

- ☐ Birth defect/congenital deformities
- ☐ Pregnancy complications
- ☐ Are you, your spouse, or any dependent child(ren) (even if not listed on the application) currently pregnant or an expected parent? (If checked, please provide the due date) _____

MUSCULAR OR SKELETAL SYSTEM

- ☐ Back/neck/spine disorder
- ☐ Bone/orthopedic disorder
- ☐ Lupus, chronic muscle pain, muscle injury or disease, or fibromyalgia
- ☐ Osteoarthritis/osteoporosis/osteopenia
- ☐ Rheumatoid arthritis
- ☐ Knee/shoulder/hip/joint surgery/disorder
- ☐ Hernia

MISCELLANEOUS

- ☐ Cosmetic surgery/implants
- ☐ Had chronic fatigue
- ☐ Any fluctuations in weight (+/- 20 lbs.) in the past 12 months
- ☐ Allergies
- ☐ Use of prosthetic devices/limbs
- ☐ Any person to be insured now disabled, on disability, or unable to perform normal work or age-related activities.
- ☐ Implantable devices/stents/shunts/pace maker
- ☐ Transplants

OTHER INJURY, ILLNESS, TREATMENT, OR CONDITION

☐ Within the last five years, has any applicant had any other injury, illness, treatment, or condition not already listed; been hospitalized or scheduled to be hospitalized; had surgery or had surgery scheduled; had a test or a test scheduled; been recommended to have a test or surgery that was not performed for any reason not already mentioned; been prescribed medication for a condition or injury not already mentioned? (We are NOT seeking the results of HIV antibody test.)

TOBACCO USE

☐ Has any applicant used tobacco products in any form within the last 12 months? (If, checked, provide the name of the applicant(s), amount of tobacco used and frequency:_____

ADDITIONAL MEDICAL DETAILS

For any medical conditions checked, please provide complete details below. Not providing complete details will delay the application process. Within the last five years, has anyone been prescribed medications that were recommended or received from a licensed health care professional? Use an additional sheet(s) of paper if necessary.

Question # or additional information								
Applicant Name								
Specific Diagnosis and type of Treatment								
Duration of Condition Began MM/YY	Began MM/YY		Began MM/YY		Began MM/YY		Began MM/YY	
	End MM/YY		End MM/YY		End MM/YY		End MM/YY	
Name/Dosage/Frequency of Medication and Dates of Medication Use	Name of Rx		Name of Rx		Name of Rx		Name of Rx	
	Dose		Dose		Dose		Dose	
	Began MM/YY		Began MM/YY		Began MM/YY		Began MM/YY	
	End MM/YY		End MM/YY		End MM/YY		End MM/YY	
Was surgery performed	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Description of surgery/ Procedures/Tests/Result and Dates								
	Date		Date		Date		Date	
Readings for blood pressure, cholesterol and diabetes	Date	Reading	Date	Reading	Date	Reading	Date	Reading
Physician/Hospital Name, City, and State								

Answers to the medical questions should be complete, true, and correct to the best of your knowledge. You are required to promptly notify us if there is a change in your or your family's health prior to the effective date of coverage and provide updated information. If at any time during the underwriting process prior to the effective date of coverage, you or your health history changes, please notify us immediately as this may impact your coverage.

3. 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 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; • 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; • 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); and • 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.

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.

SIGN HERE ⊠ _____

Applicant's Signature Date

4. Your Premium Payment Options *(Business checks and/or accounts cannot be used for premium payment)*

Please check the method of payment you are requesting below:

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

☐ **CREDIT/DEBIT CARD.** Please visit pay.wpsic.com

☐ **AUTOMATIC WITHDRAWAL.** We electronically transfer your premium directly from your bank account—just fill out the payment authorization information:

Account Type	☐ Checking Account ☐ Savings Account
Account Holder Name	
Routing Number	
Account Number	
Bank Name	
Withdrawal Date	☐ First day of the month ☐ 20th of the month prior

5. Agent Statement

Writing Agent's Name	Agency Name
Writing Agent's Signature	Agent's Phone Number
Writing Agent's NPN Number	Date Signed by Agent

6. Authorization Notice

Notice Authorization to release medical records: I hereby authorize any licensed physician, medical practitioner, health care provider, hospital, clinic, or other medical or medically related facility, insurance or reinsuring company, Medical Information Bureau, Inc. ("MIB'), Pharmacy Benefit Managers, consumer reporting agency, or other organization, institution, or person that has any record or knowledge of me or my minor children to give to the Insurer or its legal representative, reinsurers, authorized agents or designees, any and all information (including information that constitutes protected health information as defined in the privacy regulation promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996, as amended ["HIPAA Privacy Regulation"], but excluding psychotherapy notes, if any) in any form, including, but not limited to, in original, electronic, or photographic copies, about me or my minor children to be covered concerning diagnosis, treatment, and prognosis for any physical or mental condition, history or character, general reputation, personal traits, and mode of living, including, but not limited to, all medical and health care records. The information authorized for release shall not include whether the individual has obtained a test for the presence of HIV, antigen or nonantigenic products of HIV, or an antibody to HIV, or the results of such a test, if obtained by the individual. I understand the information obtained by this authorization will be used by the Insurer to determine eligibility for coverage under this policy, and that my failure to authorize the release of said information might result in a refusal to issue or provide coverage. I agree that the Insurer may release said information to MIB or to WPS' reinsuring companies, representative(s), or other person (s) performing business or legal services in connection with this application or as may be permitted or required by law, or as I may further authorize from time to time. I understand that I may revoke this authorization by providing advance written notice of termination to the Insurer and that any information released in reliance upon this authorization and prior to such revocation cannot be retrieved. In such case, the Insurer, its directors, officers, employees, and agents shall not be held responsible or liable for such release. I understand this authorization will remain valid for 30 months from the date I execute this authorization unless revoked by me in writing prior to the end of that 30-month period. I understand that I am entitled to receive a copy of this completed, signed authorization, and that a photographic copy shall be as valid as the original. I understand that once information is disclosed pursuant to this authorization, it may no longer be protected by the HIPAA Privacy Regulation and could be re-disclosed by the person or entity that receives it.

SIGN HERE ⊠

Applicant's Signature Date

Spouse's Signature Date

Contact Information

Mail to: WPS
P.O. BOX 8190 , Madison, WI 53708-8190

Other options to submit application:
Fax: 608-223-3639
Email: billing@wpsic.com