EMPLOYEE GROUP ENROLLMENT APPLICATION

WPS HEALTH INSURANCE

Wisconsin Physicians Service Insurance Corporation ("WPS") ("Insurer") or Third-Party Administrator ("TPA") does NOT guarantee approval of this application for any person, or issuance of a policy. When complete, please mail this application to the appropriate company shown on Page 5.

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	Height/Weight
☐ 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 member 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
- ☐ Domestic partner 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 Health 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	Height	Weight	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 Date of Birth: _____			❍ Single ❍ Family	
			☐ COBRA	COBRA Effective Date: COBRA Termination Date:
Name: _____ ❍ Employee ❍ Spouse/Domestic Partner 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 7A—Medical Information

1. **Total Disability.** Is anyone named in this application now disabled or unable to perform normal work- or age-related activities?

   ❍ Yes ❍ No

   If yes, please identify names, conditions, dates of disability, and name and address of attending physician:

   _____

   _____

2. Within the past six months, has anyone named in this application who is age 18 or over used tobacco regularly (four or more times per week on average)? ☐ Yes ☐ No
If yes, please list which applicants: _____

Section 7B—Medical Information—Health Questionnaire

DO NOT COMPLETE THIS SECTION IF YOU ARE ENROLLING AS A NEW HIRE OR LATE ENROLLEE INTO AN EXISTING PLAN. If you are enrolling for coverage(s) as part of a new group, please fill out the appropriate subsection below according to the number of employees *enrolled* in the group plan. Please note: you are required to forward to the Insurer or TPA any changes and/or dependents in your or any family member's health history that occur prior to your receipt of our written underwriting decisions on this application.

1. **Groups 250+ Enrolled Employees**

   Is anyone named on this application being considered for, on a list for, or scheduled for a transplant? ☐ Yes ☐ No

2. **Groups with 26 to 249 Enrolled Employees**

   a. Within the last 24 months, has anyone named in this application consulted, received treatment, had medication prescribed by a doctor, psychiatrist, psychologist, or other practitioner or been diagnosed for: (a) cancer, (b) stroke, (c) diabetes, (d) heart or vascular disease, (e) multiple sclerosis, (f) muscular or systemic disease (such as arthritis, lupus), (g) transplant, (h) liver, kidney, lung, or intestinal disorder (except genetic testing results), (i) blood disorder, or (j) Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)? (AIDS tests received at anonymous counseling and testing sites or through home test kits need not be revealed. *We are not seeking the results of HIV antibody Test.*) (Questions designed to elicit information regarding AIDS, ARC, and HIV must be specifically related to the testing, diagnosis, or treatment done by a physician or an appropriately licensed clinical acting within the scope of his/her license.) ☐Yes ☐No

   a. Are you or any dependent (even if not listed on application) pregnant or been advised in the last 12 months that hospitalization, surgery, or treatment is needed or pending? ☐Yes ☐ No (If yes, expected due date is_____)

   b. Are you or any dependent named in this application currently taking any prescribed medications? ☐ Yes ☐ No

3. **Groups with 2 to 25 Enrolled Employees**

   b. Are you or any other dependent (even if not listed on application) currently pregnant? ☐ Yes ☐ No
   (If yes, expected due date is: _____)

   c. Is anyone named in this application currently taking any medications recommended or prescribed by a physician or other health care practitioner? ☐ Yes ☐ No

   d. Has anyone named in this application had medication recommended or prescribed by a physician or other health care practitioner within the past 12 months? ☐ Yes ☐ No

   e. Has anyone named in this application had a professional diagnosis of Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)? (AIDS tests received at anonymous counseling and testing sites or through home test kits need not be revealed. *We are not seeking the results of HIV Antibody Test.*) (Questions designed to elicit information regarding AIDS, ARC, and HIV must be specifically related to the testing, diagnosis or treatment done by a physician or an appropriately licensed clinical acting within the scope of his/her license.) ☐ Yes ☐ No

   f. Within the last five years, has anyone named in this application been hospitalized or scheduled for hospitalization; had surgery or surgery scheduled; had a test or test scheduled; or been recommended to have a test or surgery that was not performed for any reason not already mentioned? ☐ Yes ☐ No

   g. Within the last five years, has anyone named in this application been counseled, consulted, or treated for any of the following conditions: (1) heart disease or disorder; (2) stroke; (3) circulatory disorder; (4) high blood pressure; (5) diabetes; (6) connective tissue disorder; (7) allergies; (8) asthma; (9) emphysema; (10) sinus; (11) nasal or lung disease or disorder; (12) ulcers; (13) stomach or intestinal disorder; (14) thyroid disorder; (15) adrenal disorder; (16) enlargement of the lymph-nodes; (17) menstrual or gynecological disorder; (18) infertility; (19) sexual dysfunction; (20) arthritis; (21) back, joint, or muscle disorder; (22) ear, skin, or eye disorder; (23) cancer; (24) tumor; (25) abnormal growth; (26) nervous system disorder (including attention deficit and psychological disorders and multiple sclerosis); (27) headaches; (28) seizures; (29) epilepsy; (30) hepatitis; (31) liver disorder; (32) kidney, bladder, or prostate disorder; (33) hernia; (34) rectal disorder; (35) anemia; (36) blood disorder; (37) the use of alcohol, chemicals, or drugs (been advised to cease or decrease use of); or (38) transplant. ☐Yes ☐ No
   If yes, please indicate which conditions using the corresponding numbers from above: _____

4. In the spaces below, please list medications and provide full details to questions for which you answered "yes" above. If you need additional space, please attach a separate sheet of paper.

Question No.	Family Member	Date of Treatment	Identify the medication, condition, its duration, treatment, and degree of recovery	Name/Address of Attending Physician

Section 8—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, 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, 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 9—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 you 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, birth or adoption of a child) after you 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, 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, 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 10—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 Insurer or 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 Insurer or 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. This document will become a part of the insurance contract when coverage is approved and issued.

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 Insurer or 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 Insurer or TPA and signed by an authorized officer of the insurer or TPA. I agree that no insurance will be effective until the date specified by the company on the policy 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 Insurer or TPA's approval.

Name of Person Providing Assistance (if applicable): _____

Section 11—Acknowledgement and Signatures

I acknowledge that:

- This application becomes part of my Medical Coverage Agreement.
- The signatures shown below allow me, my spouse/domestic partner to release to Insurer or TPA information about any person listed on my Individual and Family plan application documents.
- Under the Health Insurance Portability and Accountability Act (HIPAA), Insurer or 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.
- Insurer or 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 Medical Coverage Agreement.
- I have read and agree to the Terms and Conditions (Section 10) 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, the Medical Coverage Agreement 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.

For more information on Special Enrollment Period requirements, please visit wpshealth.com.

❑ **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:

WPS Health Insurance
P.O. Box 8190
Madison, WI 53708-8190

Call:

888-915-5618

Visit:

wpshealth.com