

Electronic Enrollment Election Form

Instructions: Wisconsin Physicians Service Insurance Corporation groups will need to complete this form if the group wishes to (a) electronically transmit enrollment information and/or (b) use their own paper enrollment form, instead of having employees complete and submit WPS' standard employee application forms. Any questions about this form should be directed to

By signing below and electing to process enrollments electronically for _____ ("Group"),
I certify as Group's authorized representative that Group understands and agrees to the following terms and conditions:

1. Group will inform its members of their special enrollment rights for health coverage. A sample Notice of Special Enrollment Rights for Health Coverage is attached for your reference.
2. WPS will not be responsible for obtaining documentation regarding any member's waiver of health insurance coverage. Group will have each employee who is waiving or declining health insurance coverage provide written confirmation that he/she is declining coverage and the reason he/she is declining coverage. A sample Employee Health Coverage Waiver form is attached for your reference. If you are a small group employer (2-50 employees), you are responsible for forwarding any completed waivers to WPS within 30 days of the date the employee becomes eligible to enroll in your group health plan. Large group employers (51+ employees) are required to maintain copies of the completed waivers and provide them upon request to WPS.
3. Group agrees to provide accurate and complete information to WPS and to only enroll members that are presently eligible for coverage.
4. Group understands and agrees that the electronic enrollment information provided will be used by WPS to determine eligibility for benefits and will become a part of the insurance contract when coverage is approved and issued. WPS will rely upon Group to ensure all enrollment information provided is accurate and complete.
5. Initial enrollment information should not be submitted more than 60 days prior to the effective date.
6. Group agrees that WPS is not liable for any statement, representation, or other information provided to Group or any of its members that is not expressly contained in a written document provided by WPS and signed by an authorized officer of WPS.
7. Group agrees that no insurance will be effective until the date specified by WPS.
8. WPS may collect, use, or disclose the nonpublic personal information of Group's enrollees as required or permitted by law.
9. Group certifies that any enrollment information it provides to WPS will be accurate and complete to the best of its knowledge and that any individual for whom it is requesting enrollment is eligible for coverage. Group, on behalf of its members and their dependents, agrees to cooperate in providing WPS any additional information needed to complete the enrollment process.
10. Group understands that if it has made intentionally false or misleading statements on behalf of itself or any of its members, its Group Policy with WPS may be canceled retroactively to its effective date.
11. Group understands that it is illegal to knowingly provide false, incomplete, or misleading information to fraudulently obtain health coverage. Penalties may include imprisonment, fines, and denial of benefits.

SIGNATURE OF GROUP REPRESENTATIVE

DATE

PRINT NAME OF GROUP REPRESENTATIVE

Submit your completed form to

Sample Notice of Special Enrollment Rights for Health Coverage

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

If you are declining enrollment for yourself or your dependents (including your spouse) 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, 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 because of marriage, 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, birth, adoption or placement for adoption.

To request special enrollment or obtain more information, contact

Sample Employee Health Coverage Waiver

I understand and affirm that I am waiving or declining health insurance coverage offered by ("Group") for the persons named below because (select all that apply): I am covered or will be covered under another plan not sponsored by Group; my dependents are covered/will be covered under another plan not sponsored by Group; other, please explain: _____

Names of persons waiving/declining coverage:

By signing below, 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 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) because of other health coverage, I may in the future enroll myself or my dependents in this plan, if I request enrollment within 31 days after my coverage ends (or 60 days for loss of Medicaid eligibility).
- If I have a new dependent because of marriage, birth, adoption or placement for adoption, I understand that I may be able to enroll myself and my dependents if I request enrollment within 31 days after the marriage or within 60 days after the birth or adoption.
- I understand that after the enrollment period, other than these qualifying events, I cannot enroll until the next Annual Enrollment Period.

SIGNATURE OF EMPLOYEE (required if waiving coverage)

DATE

PRINT NAME