WPS Short-Term Health Insurance Plan Application for Coverage

WPS HEALTH INSURANCE

Mail this application to:
WPS Health Insurance • P.O. Box 8190 • Madison, WI 53708-8190
Other options to submit application:
FAX: 608-223-3639 • Email: billing@wpsic.com

wpshealth.com | 800-332-6421

Internal use only

INSTRUCTIONS: Please complete the entire application. Please print using black ink. WPS ("the Insurer") does 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 WPS Individual Sales Representative.

1. Information About You (Primary Applicant)

Your Name Last	First	Middle Initial
Social Security Number / Birth Date	Gender ☐ Male ☐ Female	
Primary Address Number and Street	City / State / ZIP / County	
Mailing Address (if applicable) P.O. Box/Number and Street	City / State / ZIP / County	
Email Address	Best phone number to reach you during daytime hours	

Required: Does anyone named on this application currently have health insurance coverage: ☐ Yes ☐ No

If you answered yes to the previous question, will this mentioned coverage be terminated upon approval of this policy? ☐ Yes ☐ No

*Please note: If prior coverage will not be terminated, this policy cannot be issued.

WPS is committed to an eco-friendly environment. The communications you receive from us will be available in your online customer account.

2. Information About Your Family (if enrolling dependents, please complete this section)

Last Name	First Name	MI	Birth Date	Gender	Social Security Number	Relationship to Applicant
Spouse						
Dependents/Children						

3. United States Citizenship or Resident Legal Alien

Are you, your spouse, or any named dependent a citizen of the United States or resident legal alien? ☐ Yes ☐ No

If no, indicate who: ☐ Primary ☐ Spouse ☐ Dependent 1 ☐ Dependent 2 ☐ Dependent 3

If you answer "No" to the questions above, that individual is not eligible for the coverage and benefit plan you are requesting.

4. Type of Coverage and Benefits Plan (Please check plan option you are requesting)

Please select your plan	Deductible		Coinsurance		Out-of-Pocket Maximum	
	In-Network Individual/Family	**Out-of-Network** Individual/Family	**In-Network**	**Out-of-Network**	**In-Network** Individual/Family	**Out-of-Network** Individual/Family
☐	$1,500/$4,500	$3,000/$9,000	25%	50%	$4,000/$12,000	$8,000/$24,000
☐	$2,500/$7,500	$5,000/$15,000	0%	50%	$2,500/$7,500	$10,000/$30,000
☐	$2,500/$7,500	$5,000/$15,000	25%	50%	$5,000/$15,000	$10,000/$30,000
☐	$5,000/$15,000	$10,000/$30,000	0%	50%	$5,000/$15,000	$15,000/$45,000
☐	$5,000/$15,000	$10,000/$30,000	25%	50%	$7,500/$22,500	$15,000/$45,000
☐	$10,000/$30,000	$20,000/$60,000	0%	50%	$10,000/$30,000	$25,000/$75,000
☐	$10,000/$30,000	$20,000/$60,000	25%	50%	$12,500/$37,500	$25,000/$75,000
☐	$15,000/$45,000	$30,000/$90,000	25%	50%	$17,500/$52,500	$35,000/$105,000

5. Coverage Period

Please indicate your requested effective date _____

If this application is approved by Insurer, the policy effective date will be determined by the Insurer subject to a) receipt date of application and b) completeness of application. Earliest effective date would be date following receipt.

Please indicate your requested termination date as of 11:59 p.m. _____

The coverage period must be at least one month, but less than one year.

You may apply for additional WPS Short-Term Plans upon policy termination. The consecutive periods may not exceed 18 months.

6. Information About You and Your Family's Health

ANY MISREPRESENTATION MAY BE USED TO DENY A CLAIM OR TO RESCIND AND VOID THE POLICY.

	Yes	No
1. Have you, your spouse or any dependent named on this application ever been denied health insurance due to health reasons? If yes, select each person: ☐ Primary ☐ Spouse ☐ Dependent 1 ☐ Dependent 2 ☐ Dependent 3	☐	☐
2. Are you or any family member (whether or not named in this application) an expectant mother or father, in the process of adopting a child, or undergoing infertility treatment? If yes, select each person: ☐ Primary ☐ Spouse ☐ Dependent 1 ☐ Dependent 2 ☐ Dependent 3	☐	☐
3. Within the past five years, have you, your spouse, or any dependent named on this application: (you do not need to reveal HIV or genetic testing results)		
a. Had any medical condition for which future testing, surgery, or hospitalization is scheduled, planned, recommended, or warranted? If yes, select each person: ☐ Primary ☐ Spouse ☐ Dependent 1 ☐ Dependent 2 ☐ Dependent 3	☐	☐
b. Had signs or symptoms of any undiagnosed illness or an injury for which it may be necessary to seek medical services or treatment in the future? If yes, select each person: ☐ Primary ☐ Spouse ☐ Dependent 1 ☐ Dependent 2 ☐ Dependent 3	☐	☐
c. Had any testing performed for which they have not received the results? If yes, select each person: ☐ Primary ☐ Spouse ☐ Dependent 1 ☐ Dependent 2 ☐ Dependent 3	☐	☐
4. Are you, your spouse, or anyone applying for coverage over 300 pounds if male, or 250 pounds if female? If yes, select each person: ☐ Primary ☐ Spouse ☐ Dependent 1 ☐ Dependent 2 ☐ Dependent 3	☐	☐
5. Within the past five years, have you, your spouse, or any dependent named on this application:		
a. Been diagnosed with, treated for, had medication prescribed for, been hospitalized for, or had symptoms of: arthritis, degenerative joint or disc disease; joint replacement; Muscular Dystrophy; paralysis, epilepsy; seizure disorder; neurological or genetic disease or disorder; cancer; tumors; stroke or transient ischemic attack (TIA); alcohol, drug, or chemical dependency; hearing impairment; eating disorder; developmental disorder; mental illness, including treatment by a psychiatrist more than five times in the last 12 months; diabetes; multiple sclerosis; fibromyalgia; or disease or disorder of the intestines or bone marrow? If yes, select each person: ☐ Primary ☐ Spouse ☐ Dependent 1 ☐ Dependent 2 ☐ Dependent 3	☐	☐
b. Been diagnosed with, treated for, had medication prescribed for, or had symptoms of the following diseases or disorders: Blood, liver, pancreas, kidney, heart or circulatory (excluding high blood pressure), lung (excluding asthma), or brain? If yes, select each person: ☐ Primary ☐ Spouse ☐ Dependent 1 ☐ Dependent 2 ☐ Dependent 3	☐	☐
c. Been diagnosed with, treated for, had medication prescribed for, or had symptoms of any disease or disorder of the lymph nodes or immune system (including autoimmune)? If yes, select each person: ☐ Primary ☐ Spouse ☐ Dependent 1 ☐ Dependent 2 ☐ Dependent 3	☐	☐
d. Had, or been considered for, an organ, stem cell, or bone marrow transplant? If yes, select each person: ☐ Primary ☐ Spouse ☐ Dependent 1 ☐ Dependent 2 ☐ Dependent 3	☐	☐
e. Have a birth defect and/or congenital disorder/deformity? If yes, select each person: ☐ Primary ☐ Spouse ☐ Dependent 1 ☐ Dependent 2 ☐ Dependent 3	☐	☐
f. **Note: You need not reveal HIV tests or the results of HIV tests. You need not reveal genetic tests or the results of genetic tests.** Been diagnosed or treated by a member of the medical profession for AIDS or any HIV-related disease or illness? If yes, select each person: ☐ Primary ☐ Spouse ☐ Dependent 1 ☐ Dependent 2 ☐ Dependent 3	☐	☐

Note: If you, your spouse, or any dependent child(ren) answered yes to any of the above questions, that person is not eligible for coverage. You should remove them from this application and not submit their name for coverage. If the primary applicant is such person, do not proceed further and do not submit this application to WPS.

7. 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. **A 2% discount will be applied with this option.**

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

8. Authorization/Certification/Understanding 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 Manager, consumer reporting agency, or other organization, institution, or person that has any record or knowledge of me or my minor children to give to Wisconsin Physicians Service Insurance Corporation ("WPS") 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, 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 WPS 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 WPS 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 WPS at its office in Madison, Wisconsin, and that any information released in reliance upon this authorization and prior to such revocation cannot be retrieved. In such case, WPS, 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 the WPS Short-Term Insurance Plan will not provide benefits for any illness or injury occurring before the effective date of the policy. I understand that expenses for an illness are eligible for coverage beginning on the seventh day following the effective date. I understand the policy is not renewable. I further understand and agree that WPS, its directors, officers, employees, and agents shall not be liable for any injury, damage, or expense (including attorney's fees) I, my spouse, or any dependent(s) suffer as a result of any improper advice, action, or omission on the part of any health care provider. I have reviewed the WPS Short-Term Plan brochure and have determined that this policy is suitable for me.

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.

CERTIFICATION: I represent and certify all of the following: no answer or information 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: the representations I make, together with any supplemental representations that I make, shall be the basis for the Insurer to issue any coverage; 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; that no coverage will be effective unless and until the date specified by the Insurer after this application has been approved by the Insurer; 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.

I understand that 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). Furthermore, I understand that 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.

I understand and acknowledge that any person who, with intent to defraud or knowledge that he/she is facilitating a fraud against an Insurer, submits an application or files a claim containing a false and deceptive statement is committing a fraudulent act, which is a crime. I further understand and acknowledge that in some states, any person who, for the purpose of misleading an Insurer or other person, conceals significant information from an application or claim is committing a fraudulent act.

9. Coverage Notice

This coverage is not required to comply with certain federal market requirements for health insurance, principally those contained in the Affordable Care Act. Be sure to check your policy carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services). Your policy might also have lifetime and/or annual dollar limits on health benefits. If this coverage expires or you lose eligibility for this coverage, you might have to wait until an open enrollment period to get other health insurance coverage.

10. Agent Statement

Did an agent or sales representative assist you in the completion of this application? ☐ Yes ☐ No
If yes, agent must complete the following:

I asked the applicant, spouse, and all child(ren) over age 18 all questions contained in this application and recorded their answers exactly as given to me. I also represent that no other person provided any of their answers or influenced any of their answers; if any of their answers were influenced by another person, I have attached a written explanation thereof to this application.

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

11. Acknowledgements and Signatures

I acknowledge that:

- This application becomes part of my Policy by endorsement.
- The signatures shown below allow me, my spouse, and/or dependent child(ren) over the age of 18, to release to Insurer information about any person listed on my Individual and Family plan application documents.
- Under the Health Insurance Portability and Accountability Act (HIPAA), Insurer without my authorization may only release limited information about my selection of a plan to my spouse, adult/minor children, producer, or anyone else.
- Insurer 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, paying claims, and, if appropriate, coordinating benefits and fulfilling other legal obligations specified in my policy.
- I have read and agree to the Authorization/Certification/Understanding Notice (Section 8) included with this application.
- I have read and understand the Coverage Notice (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, the policy 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.

☐ **Signature:** This application has been signed by me, my spouse, or dependent child(ren) over the age of 18, 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 signature (if applicable):_____ Date:_____

Child over age 18's signature (if applicable):_____ Date:_____

Child over age 18's signature (if applicable):_____ Date:_____

Child over age 18's signature (if applicable):_____ Date:_____

WPS HEALTH INSURANCE