INDIVIDUAL POLICY APPLICATION

Internal use only

WPS HEALTH PLAN

The health plans are available in the following counties: Brown, Calumet, Dodge, Door, Fond du Lac, Green Lake, Kenosha, Kewaunee, Manitowoc, Marinette, Marquette, Milwaukee, Oconto, Outagamie, Ozaukee, Racine, Shawano, Sheboygan, Washington, Waukesha, Waupaca, Waushara, Winnebago

DELTA DENTAL®

Instructions: Please complete all applicable areas of this application. Please print using **black** ink. WPS Health Plan, Inc./Delta Dental of Wisconsin 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 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

Marital Status

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Best phone number to reach you during daytime hours

Cell Phone Number:

By providing WPS Health Plan with your cell phone number and email address, you are providing consent for us to contact you by these methods.

Race or ethnicity

- ☐ Caucasian/White
- ☐ African American/Black
- ☐ American Indian or Alaska 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
- ☐ Dutch
- ☐ French
- ☐ German
- ☐ Hmong
- ☐ Korean
- ☐ Laotian
- ☐ Pennsylvania Dutch
- ☐ Polish
- ☐ Russian
- ☐ Spanish
- ☐ Tagalog
- ☐ Vietnamese
- ☐ Other: _____

WPS Health Plan is committed to supporting an eco-friendly environment. The communication 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. Policy Effective Date *(If this application is approved by Insurer, the policy effective date is determined only by the Insurer)*

Please indicate your requested effective date. Please note, the effective date can be no later than 60 days from the date of application.

_____ The Policy Effective Date will be determined by the Insurer, subject to any applicable law or policy provisions.

4. Information on Eligibility

A. 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? ☐ Yes ☐ No

If yes, please list which applicants: _____

B. Are you applying due to a qualifying life event (special enrollment)? ☐ No ☐ Yes—date of the qualifying life event: _____

If yes, choose: ☐ Decrease in household income

☐ Involuntary loss of Minimum Essential Coverage for any reason other than fraud, intentional misrepresentation of a material fact, or failure to pay premium

☐ Was previous coverage under COBRA? ☐ Yes ☐ No
If yes, please indicate your COBRA start date _____

☐ Marriage—(At least one spouse has to demonstrate they had minimum essential coverage within the 60 days preceding)

☐ Birth ☐ Adoption or placement for adoption or appointment of guardianship

☐ Renewal of non-calendar year policy ☐ Placement in foster care

☐ Permanent move and had minimum essential coverage within 60 days

☐ Other: _____

5. Type of Coverage and Benefit Plans

A. **Types of Coverage and Benefits Plan**—Please refer to your policy for any non-participating provider benefits.

Deductibles and out-of-pocket maximums listed below are for individuals. Family deductibles are two times the individual. Please see Summary of Benefits and Coverage for more detailed policy benefits.

Selection	Metal Tier	Deductible	Coinsurance (amount you pay)	Out-of-Pocket Limit	Convenient Care Clinic Copay	PCP Copay	Specialist Copay	**Prescription Plan** Preventive/Preferred Generic Non-preferred Generic/Preferred Brand/ Non-preferred Brand/Specialty
☐ HMO	Gold	$2,000	25%	$8,700	$30	$30	$60	$0 / $15 / $15 / $30 / $60 / $250
☐ HMO	Silver	$4,500	30%	$9,100	$10	$45	$90	$0 / $15 / $25 / $75 / $150 / D/C
☐ HMO	Silver	$5,800	40%	$8,900	$40	$40	$80	$0 / $20 / $20 / $40 / $80 after plan Ded./ $350 after plan Ded.
☐ HMO	Silver	$7,800	0%	$7,800	$10	$45	$90	$0 / $15 / $25 / $75 / $150 / D/C
☐ HMO HDHP	Silver	$3,440	20%	$7,500	D/C	D/C	D/C	$0 preventive, D/C all others
☐ HMO HDHP	Silver	$5,000	0%	$5,000	D/C	D/C	D/C	$0 preventive, D/C all others
☐ HMO HDHP	Silver	$5,440	0%	$5,440	D/C	D/C	D/C	$0 preventive, D/C all others
☐ HMO	Bronze	$6,500	20%	$9,100	D/C	D/C	D/C	$0 preventive, D/C all others
☐ HMO	Bronze	$7,500	40%	$9,100	D/C	D/C	D/C	$0 / $15 / $30 / $125 / $250 / D/C
☐ HMO ☐ POS	Bronze	$9,100	0%	$9,100	D/C	D/C	D/C	$0 preventive, D/C all others
☐ HMO HDHP ☐ POS HDHP	Bronze	$6,000	30%	$7,500	D/C	D/C	D/C	$0 preventive, D/C all others
☐ HMO HDHP	Bronze	$7,000	0%	$7,000	D/C	D/C	D/C	$0 preventive, D/C all others
☐ HMO HDHP	Bronze	$7,500	0%	$7,500	D/C	D/C	D/C	$0 preventive, D/C all others
☐ HMO	Catastrophic*	$9,100	0%	$9,100	D/C	D/C	D/C	$0 preventive, D/C all others

D/C = Deductible and Coinsurance PCP = Primary Care Practitioner

*** Eligibility limited to persons under age 30 or those with a hardship exemption from the Federally Facilitated Marketplace.**

B. **Are you applying for dental coverage?** ☐ Yes ☐ No

Dental Benefit Plan (administered through Delta Dental of Wisconsin)

The dental plan is only available if you select one of the health plans shown above.

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.

C. **Coverage Selection**

Please choose the type of coverage you are applying for:

☐ Applicant ☐ Applicant and Spouse ☐ Applicant and Child(ren) ☐ Applicant, Spouse, and Child(ren) ☐ Child(ren) Only

D. **Primary Care Practitioner**

Please select a Primary Care Practitioner (PCP) for yourself, your spouse, and each dependent who is applying for coverage.

Last Name	First Name	MI	Primary Care Practitioner

6. Information About Other Medical Coverage

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

B. If you answered "Yes" to A, above, please provide the following information:

Name	Current Health Carrier	Policy or Group Number Effective Date	Will coverage terminate upon approval of this policy? ☐ Yes ☐ No Termination Date
Name	Current Health Carrier	Policy or Group Number Effective Date	Will coverage terminate upon approval of this policy? ☐ Yes ☐ No Termination Date

C. Is any person named on this application currently eligible for Medicare? ☐ Yes ☐ No

D. If you answered "Yes" to C, above, please indicate who: _____

*Please note, anyone named on this application who is enrolled for Medicare will not be covered by this policy.

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.wpshealthplan.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

8. Certification/Understanding Notice

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.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

IF YOU ARE REPLACING OTHER INDIVIDUAL OR GROUP HEALTH COVERAGE, PLEASE READ THIS SECTION.

According to your application or the information furnished by you, you intend to lapse or otherwise terminate your present policy and replace it with a policy to be issued by the Insurer. For your own information and protection, certain facts shown below should be pointed out to you. If the Insurer approves your application for coverage and issues a policy, you should consider these facts before you lapse or terminate your present policy.

- Your new policy provides a time limit within which you may decide, without cost to you, whether you desire to keep the policy. The time limit is 10 days from the date of receipt of this policy.
- Health conditions which you presently may have might not be covered under the new policy. This change in coverage could result in a claim for benefits being denied under the new policy even though they are payable under your present policy.
- Questions in the application for the new policy must be answered truthfully and completely; if not, the validity of the policy and the payment of any benefits thereunder may be rescinded and voided.

9. 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 _____

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 Third Party Administrator ("TPA") to determine eligibility for benefits. I, on behalf of myself, my spouse, and my dependent child(ren), if any, named herein, agree to cooperate in providing Insurer or TPA with information needed to process this Application.

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, 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):_____

11. Acknowledgements and Signatures

I acknowledge that:

- This application becomes part of my Medical Coverage Agreement.
- The signatures shown below allow me, my spouse, or my agent (Section 9) 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, reviewing prior coverage for waiting periods, paying claims, and, if appropriate, coordinating benefits, and fulfilling other legal obligations specified in my Insurer Medical Coverage Agreement.
- I have read and agree to the Terms and Conditions (Section 10) included with this application.
- I authorize Insurer to disclose information about the selection of a plan to the Agent of Record (Section 9) for the duration of coverage and final reconciliation of the Insurer account. A signed Customer Authorization to Disclose Health Plan Information form is required for all other disclosures to the Agent of Record.

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.

☐ **Signature:** This application has been signed by me and my spouse, 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_____

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

Internal Use Only—Notes