



# INDIVIDUAL POLICY SUPPLEMENTAL CHANGE APPLICATION

Mail this Supplemental Application Along with the Individual Uniform Application to:  
**Wisconsin Physicians Service Insurance Corporation**  
 P.O. Box 7898 • Madison, Wisconsin 53707

Instructions: Please complete the entire application. Please print using **black** ink. WPS/Delta Dental of Wisconsin ("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.

**Note: Only complete this change application if you are making a change to your current policy. If you would like to apply for the currently marketed plan, please complete the Individual Uniform Application along with the WPS Supplemental Application. (This would be subject to our full medical underwriting requirements.)**

Customer Name \_\_\_\_\_

Customer Number \_\_\_\_\_ Social Security Number \_\_\_\_\_

## 1. Information Changes

### A. CHANGE NAME

From: \_\_\_\_\_  
Last First Middle Initial

To: \_\_\_\_\_  
Last First Middle Initial

Effective Date of Change: \_\_\_\_\_ (Check one:)  Customer  Spouse  Dependent Child

### B. CHANGE ADDRESS

Current Address: \_\_\_\_\_  
Number and Street City County State Zip

New Address: \_\_\_\_\_  
Number and Street City County State Zip

Effective Date of Change: \_\_\_\_\_ 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 WPS Sales Representative.

### C. CHANGE BENEFITS\* Please contact your agent or WPS Sales Representative for Benefit Options available to you.

#### 1. Change Deductible and/or Coinsurance on Individual Preferred Plan

- a. Deductible: Current Deductible: \_\_\_\_\_  
 Change to:  \$500  \$1,000  \$1,500  \$2,000  \$2,500  \$3,500  \$5,000  \$6,000  \$7,500  Other \_\_\_\_\_  
 Drug: If you selected the \$500, \$1,000, \$1,500, or \$2,000 deductible option, choose one of the following:  
 \$15/\$40/\$60 copay  No Drug Coverage  
 If you selected the \$2,500, \$3,500, \$5,000, \$6,000 or \$7,500 deductible option, choose one of the following:  
 \$250 deductible, then 50%  No Drug Coverage
- b. Coinsurance: Current Coinsurance: \_\_\_\_\_  
 Change to:  90%/70% of the next \$5,000  90%/70% of the next \$10,000  100%/80% of the next \$5,000  
 80%/60% of the next \$5,000  80%/60% of the next \$10,000  Other \_\_\_\_\_

#### 2. Change from Individual Preferred Plan to HSA Qualified High-Deductible Health Plan

- a. **Current Preferred Plan Deductible:**  
 Change Deductible to: (choose one)  
 \$1,200 Single, \$2,400 Family  \$1,500 Single, \$3,000 Family  \$2,000 Single, \$4,000 Family  
 \$2,500 Single, \$5,000 Family  \$3,000 Single, \$6,000 Family  \$3,500 Single, \$7,000 Family  \$5,500 Single, \$11,000 Family
- b. **Current Preferred Plan Coinsurance:**  
 Change Coinsurance to: (choose one)  
 100%/80%  
 90%/70% \* \*Only available on the \$1,200/\$2,400 deductible option  
 80%/60% \*\* \*\*Not available on the \$5,500/\$11,000 deductible option
- Drug Coverage (choose one):  Prescription drugs subject to deductible and preferred coinsurance  
 No drug coverage
- Waiver of Premium Option:  Yes  No

#### 3. Change Deductible and/or Coinsurance on HSA Qualified High-Deductible Health Plan

- a. Current Deductible: \_\_\_\_\_  
 Change Deductible to: (choose one)  
 \$1,200 Single, \$2,400 Family  \$1,500 Single, \$3,000 Family  \$2,000 Single, \$4,000 Family  
 \$2,500 Single, \$5,000 Family  \$3,000 Single, \$6,000 Family  \$3,500 Single, \$7,000 Family  
 \$5,500 Single, \$11,000 Family  Other \_\_\_\_\_

## 1. Information Changes (cont.)

### 3. Change Deductible and/or Coinsurance on HSA Qualified High-Deductible Health Plan cont.

a. Current Coinsurance: \_\_\_\_\_

Change Coinsurance to: (choose one)

100%/80%

90%/70% \* \*Only available on the \$1,200/\$2,400 deductible option

80%/60% \*\* \*\*Not available on the \$5,500/\$11,000 deductible option

Drug Coverage (choose one):

Prescription drugs subject to deductible and preferred coinsurance

No drug coverage

### 4. Change from HSA Qualified High-Deductible Health Plan to Individual Preferred Plan

a. Current Deductible: \_\_\_\_\_

Change to:  \$500  \$1,000  \$1,500  \$2,000  \$2,500  \$3,500  \$5,000  \$6,000  \$7,500

Drug: If you selected the \$500, \$1,000, \$1,500 or \$2,000 deductible option, choose one of the following:

\$15/\$40/\$60 copay  No Drug Coverage

If you selected the \$2,500, \$3,500, \$5,000, \$6,500 or \$7,500 deductible option, choose one of the following:

\$250 deductible, then 50%  No Drug Coverage

b. Current Coinsurance: \_\_\_\_\_

Change to:  90%/70% of the next \$5,000  90%/70% of the next \$10,000  100%/80% of the next \$5,000

80%/60% of the next \$5,000  80%/60% of the next \$10,000

If you are increasing your deductible (example \$500 to \$1,000) and/or lowering your coinsurance, (example 90% to 80%) the effective date of the decrease for you and all your covered dependents shall be the first day of the calendar month following the receipt of this completed application by WPS Member Services Department.

If you are decreasing your deductible (example \$1,000 to \$500) and/or raising your coinsurance (example 80% to 90%), you and your covered dependents are subject to our health underwriting requirements. You must submit the **Uniform Application** with this application. If WPS approves the change you are requesting, the effective date of the change will be assigned by WPS as stated in Section 2.

### 5. Dental Change:

Add Delta Dental Plan underwritten by Delta Dental of Wisconsin – dental coverage is only available if you have selected medical coverage

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.

Delete Dental Plan.

### D. CHANGE PREFERRED PROVIDER PLAN NETWORK

Current Network: \_\_\_\_\_ New Network: \_\_\_\_\_

The effective date of the network change for you and all your covered dependents shall be the first day of the calendar month following the receipt of this completed application by WPS. **Your rates may be affected if your new network is in a different rating zone. Please contact your agent, or WPS Sales Representative.**

### E. CHANGE MATERNITY COVERAGE

Terminate Maternity Coverage Termination Date: \_\_\_\_\_/01/\_\_\_\_\_(NOTE: This option can not be added again in the future.)

### F. CHANGE PREMIUM/PAYMENT MODE (Business checks and/or accounts can not be used for premium payment.)

**Please note: In an effort to comply with Small Employer Health Insurance laws we are unable to accept business checks for payment of premium.**

Current Premium Mode: \_\_\_\_\_ Current Payment Mode: \_\_\_\_\_

Change to:

The effective date of the premium payment mode change shall be the first billing period following 30 days after we receive this change application.

AUTOMATIC WITHDRAWAL. We electronically transfer your premium directly from your bank account at the frequency you request. (If you select this option, please complete the Automatic Withdrawal Payment Authorization Form.)

Monthly Quarterly Semiannually Annually

With this option your premium payment can be drafted from your bank account.

DIRECT BILL. We send a premium notice directly to your home at the frequency you request. You return payment to WPS by the premium due date.

Monthly (with a \$7.50 billing fee)  Quarterly (with a \$7.50 billing fee)

Semiannually (with a \$7.50 billing fee)  Annually (with no billing fee)

CREDIT/DEBIT CARD. (If you select this option, please complete Credit/Debit Card Authorization Form.)

Initial Premium Deposit  Monthly  Quarterly  Semiannually  Annually

**With this option your premium payment can be charged to your credit card.**

**1. Information Changes (cont.)**

**G. ADDING DEPENDENT TO NEW OR EXISTING FAMILY COVERAGE** (Please submit with completed Uniform Application)

Change from single coverage to:

- Applicant and Spouse Coverage
- Applicant, Spouse, and Child(ren) Coverage
- Add Spouse and Child(ren) to Family Coverage
- Applicant and Child(ren) Coverage
- Add Spouse to Family Coverage
- Add Child(ren) to Family Coverage

Adding Newborn Child      Newborn's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Last First Middle Initial  
Height \_\_\_\_\_ Weight \_\_\_\_\_

Adding Adopted Child      Child's Name \_\_\_\_\_ Date of Adoption \_\_\_\_\_  
Last First Middle Initial  
Height \_\_\_\_\_ Weight \_\_\_\_\_ Date of Birth \_\_\_\_\_

Dependent Child      Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Last First Middle Initial  
Height \_\_\_\_\_ Weight \_\_\_\_\_

Reason for adding child \_\_\_\_\_

Relationship to you \_\_\_\_\_

Adding Spouse      Spouse's Name \_\_\_\_\_  
Last First Middle Initial  
Height \_\_\_\_\_ Weight \_\_\_\_\_ Date of Birth \_\_\_\_\_

Spouse's Social Security Number \_\_\_\_\_ Date of Marriage \_\_\_\_\_

**H. TERMINATING A DEPENDENT'S COVERAGE**

Dependent Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Relationship to You \_\_\_\_\_

Date of Coverage Termination \_\_\_\_\_

Reason for Coverage Termination \_\_\_\_\_

**I. OTHER COVERAGE**

If a requested change is other than a change listed in Subsections A through H above, please explain below.

---

---

---

---

---

**2. Policy Effective Date** (If this application is approved by WPS, the policy effective date is determined only by WPS.)

The policy effective date shall be, as determined by the Insurer, the later of:

- A. If the application is received by the WPS Underwriting Department in Madison, Wisconsin, on the 1st through the 25th day of the calendar month, the policy effective date will be the first day of the following calendar month (for example, an application received on January 4th will receive a February 1st effective date).
- B. If the application is received by the WPS Underwriting Department in Madison, Wisconsin, on the 26th through the last day of the calendar month, the policy effective date will be the first day of the second calendar month following the calendar month in which the application is received (for example, an application received on January 26th will receive a March 1st effective date).
- C. The policy effective date requested by the applicant, provided the requested effective date is later than the dates stated in A. and B. above, but not more than 60 days following the date of application. **Requested Policy Effective Date:** \_\_\_\_\_/01/\_\_\_\_\_ (Insert month & year.)

**3. Certification/Understanding**

**CERTIFICATION:** I represent and certify all of the following: • I have read and completed this entire application by myself, and that no other person, including the agent, completed any portion of this application unless indicated in Section 4; • I entered each and every answer myself in response to each request for information and/or question; • 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: 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 Insurers' 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 Insurers' 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 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.

**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 (if any) are complete and true. I have read and understand this application, including the Certification/Understanding section above.**

<b>SIGN HERE</b>	<i>Applicant Signature</i>	<i>Date</i>
	<i>Spouse Signature</i>	<i>Date</i>
	<i>Child over Age 18 Signature</i>	<i>Date</i>

#### 4. Agent Statement

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.  Yes  No

Writing Agent's Name (Print) \_\_\_\_\_ Agent's Phone # \_\_\_\_\_

Writing Agent's Signature \_\_\_\_\_ Agent's Fax # \_\_\_\_\_

Writing Agent's License Number \_\_\_\_\_ Date Signed by Agent \_\_\_\_/\_\_\_\_/\_\_\_\_

WPS 9 Digit Agency ID Number \_\_\_\_\_ Agency Name \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

#### 5. Authorization 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 Signature* *Date*

\_\_\_\_\_  
*Spouse Signature* *Date*

\_\_\_\_\_  
*Child over Age 18 Signature* *Date*



## Credit/Debit Card Payment Authorization Form

### A. Applicant Information

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

### B. Billing Information, if Different Than Applicant

Name as it Appears on Credit/Debit Card \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Country \_\_\_\_\_

### C. Premium Payment Mode

Select One:  Initial Premium Deposit Only

Initial Premium and Recurring  
(Please select a day from the 7th through 31st of the month for payment pull) \_\_\_\_\_

Note: Recurring premium payments will be charged to your credit/debit card on the day of the calendar month immediately preceding the premium due date, based on your selection. Recurring days available are the 7th through the 31st of the month. If a month does not contain the day you selected, payment will be pulled from your credit/debit card account on the last day of that month. We will continue to charge premiums until the policyholder notifies us to discontinue charging premiums in accordance with the WPS policy.

### D. Credit/Debit Card Authorization

Select One:  Visa  MasterCard  Discover Card

Credit/Debit Card Number \_\_\_\_\_ Card Expiration Date \_\_\_\_\_ / \_\_\_\_\_

Must be from a personal account

I hereby authorize WPS Health Insurance (WPS) or its authorized credit/debit card transaction agent(s) to bill my credit/debit card account indicated above for payment of premiums charged for the WPS insurance policy for which I'm applying. If that WPS individual policy is issued to me by WPS, I understand and agree that by executing this authorization, that action doesn't affect, waive, or change any of the policy's terms, conditions, and provisions, including that policy's premium payment and grace period provisions. I am attesting the credit/debit card listed above is a personal account; I understand the premium may not be paid from a business account.

***SIGN HERE*** 

\_\_\_\_\_  
*Applicant Signature*

\_\_\_\_\_  
*Date*

**Automatic Withdrawal Payment Authorization**

By my signature below, I authorize Wisconsin Physicians Service Insurance Corporation (WPS) to instruct my financial institution to deduct my premium payments from the account designated below. I authorize my financial institution to debit the amount of my premium from my designated account. This authorization will remain in effect until I notify WPS in writing of its termination. My notification must afford WPS and my financial institution reasonable opportunity to act on it.

**A. ACCOUNT HOLDER INFORMATION**

Name \_\_\_\_\_

WPS Customer Number (if available) \_\_\_\_\_

Address \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Payment Mode:

Select One:  Monthly  Quarterly  Semi-Annually  Annually

**B. FINANCIAL INSTITUTION INFORMATION**

Institution Name \_\_\_\_\_

Branch/Location \_\_\_\_\_

Address \_\_\_\_\_


City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Select One:  Checking Account\*  Savings Account

Please indicate the date in which you wish to have your premium payment withdrawn from your account: \_\_\_\_\_  
(If you do not indicate a date of withdrawal, the withdrawal date shall be the 20th of each month.)

Transit Number \_\_\_\_\_ Account Number \_\_\_\_\_

\*IF USING A CHECKING ACCOUNT, PLEASE ATTACH A CHECK WITH "VOID" WRITTEN ACROSS IT.

**SIGN HERE**  \_\_\_\_\_  
*Applicant Signature* *Date*