



INDIVIDUAL POLICY SUPPLEMENTAL 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 supplemental application. Please print using **black** ink. WPS/Delta Dental of Wisconsin (“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 supplemental application, please contact your agent or WPS Individual Sales Representative.

1. Information About You (Primary Applicant)

<i>Last Name</i>	<i>First Name</i>	<i>MI</i>	<i>Social Security Number</i>
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2. Information on Eligibility

- A. Are any of your dependents applying for coverage your grandchildren? Yes No
If yes, please list their names: _____
- B. Are you, your spouse, and every named dependent a citizen of the United States or a resident legal alien? Yes No
- C. Do you and your spouse reside in Wisconsin for at least six months per year? Yes No
- You are not eligible for the coverage and benefit plan you are requesting if:
- You answered “No” to questions B. and/or C. above
 - You currently have other individual or group coverage which you are not cancelling
 - You are eligible for Medicare.
- If you are not eligible, do not proceed further and do not submit this application to WPS.**
- D. If any of your dependents are eligible for Medicare, those dependents are not eligible for coverage. WPS won’t approve these persons for coverage. Dependents eligible for Medicare should not be included in your application.

3. Coverage Selection and Effective Date

If this supplemental application is approved by WPS, the policy effective date is determined only by WPS.

Requested Effective Date: ____/01/____ (mm/01/year)

Choose Coverage Type: Applicant Applicant & Spouse Applicant & Child(ren) Applicant, Spouse & Children

Choose Your Preferred Provider Network: _____

4. Health Benefit Plan Selection

- | | |
|--|--|
| <p><input type="checkbox"/> INDIVIDUAL PREFERRED PLAN
Deductible (choose one):
<input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$2,500
<input type="checkbox"/> \$3,500 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$6,000 <input type="checkbox"/> \$7,500</p> <p>Coinsurance (choose one):
<input type="checkbox"/> 100%/80% of the next \$5,000 <input type="checkbox"/> 80%/60% of the next \$5,000
<input type="checkbox"/> 90%/70% of the next \$5,000 <input type="checkbox"/> 80%/60% of the next \$10,000
<input type="checkbox"/> 90%/70% of the next \$10,000</p> <p>Drug Coverage (choose one):
If you selected the \$500, \$1,000, \$1,500 or \$2,000 deductible option, choose one of the following:
<input type="checkbox"/> \$15/\$40/\$60 copay <input type="checkbox"/> No Drug Coverage</p> <p>If you selected the \$2,500, \$3,500, \$5,000 \$6,000 or \$7,500 deductible option, choose one of the following:
<input type="checkbox"/> \$250 deductible, then 50% <input type="checkbox"/> No Drug Coverage</p> | <p><input type="checkbox"/> HSA-QUALIFIED HIGH DEDUCTIBLE PLAN
Deductible (choose one):
<input type="checkbox"/> \$1,200 Single, \$2,400 Family <input type="checkbox"/> \$3,000 Single, \$6,000 Family
<input type="checkbox"/> \$1,500 Single, \$3,000 Family <input type="checkbox"/> \$3,500 Single, \$7,000 Family
<input type="checkbox"/> \$2,000 Single, \$4,000 Family <input type="checkbox"/> \$5,500 Single, \$11,000 Family
<input type="checkbox"/> \$2,500 Single, \$5,000 Family</p> <p>Coinsurance (choose one):
<input type="checkbox"/> 100%/80%
<input type="checkbox"/> 90%/70% - only available with \$1,200 single/\$2,400 family deductible option
<input type="checkbox"/> 80%/60% - not available on the \$5,500/\$11,000 deductible option</p> <p>Drug Coverage (choose one):
<input type="checkbox"/> Drugs subject to preferred deductible and coinsurance
<input type="checkbox"/> No Drug Coverage</p> <p>Waiver of Premium Option: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
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5. Dental Benefit Plan Selection – Dental Plan underwritten by Delta Dental of Wisconsin

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

Are you applying for dental coverage? Yes No

If any person applying for coverage has other dental coverage that is not cancelling and will not be replaced, you are not eligible for the dental plan coverage.

6. Your Premium Payment Options (Business checks and/or accounts cannot be used for premium payment)

Please check the mode of payment you're requesting in either A., B., or C. below:

- A. **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 first premium payment can be drafted from your bank account.
- B. **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)
- C. **CREDIT/DEBIT CARD.** (If you select this option, please complete Credit/Debit Card Authorization Payment Form.)
 Initial Premium Deposit Monthly Quarterly Semiannually Annually
With this option, your first premium payment can be charged to your credit card.

7. Understanding/Notice

UNDERSTANDING: I understand: that: (1) 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; (2) 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; (3) 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); and (4) 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.

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 WPS. For your own information and protection, certain facts shown below should be pointed out to you. If WPS 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.
- Although some of your present health conditions may be covered under the new policy, these conditions may be subject to certain waiting periods under the new policy before coverage is effective.
- 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.

8. Agent Statement/Information

Did an agent or sales representative assist you in the selection of this plan? 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 _____ Agent's Fax _____

Writing Agent's License# _____ Agency's 9 Digit ID# _____

Agency Name: _____

Agent's Signature _____ Date Signed by Agent _____

9. Authorization to Permit Use and Disclosure of Health Information

This shaded area to be completed by WPS.

Customer Name: _____ Date of Birth: _____

Customer Number _____

Person/Organizations authorized to *provide* the information: _____

I hereby authorize the following use or disclosure of my individually identifiable health information:

- Specific description of information to be used or disclosed: Medical records and office visit notes
- Specific purpose of the use or disclosure: Underwriting and for the purpose of creating an insurance policy
- Person/organizations authorized to *receive* the information: Health Underwriting
WPS Health Insurance
P.O. Box 7898,
Madison, WI 53707-7898

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 the Insurer 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.

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 Section 7. Understanding/Notice and Section 9. Authorization to Permit Use and Disclosure of Health Information.

(Please sign in **black** ink)

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

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

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