WPS HEALTH INSURANCE®

1717 W. Broadway — P.O. 8190 — 53708-8190

Employee's Self-Funded Plan Enrollment Application

Employer Information - This section to be completed by your employer.

Employer Name: ______________________ Employer Phone Number: ______________________

Group Number: __________ Division: __________ Class: __________ Department: __________

Employee Instructions: Please print in black ink. Please fill out the entire application for anyone applying for coverage. Remember, as the **employee**, you must be applying for coverage for anyone else in the family to be eligible.

I. Reason For Application

Please indicate if you are:

❑ A new group enrollee

❑ A new hire in an existing group (you must apply within your enrollment period) Requested Effective Date: ______________

❑ An employee who previously waived coverage and is applying due to:

❑ loss of other coverage - date:__________ ❑ birth of a child ❑ adoption of a child ❑ marriage ❑ other: __________

❑ A late enrollee

❑ Adding a Dependent - Name: ______________ Effective Date: ______________

❑ Deleting a Dependent - Name: ______________ Effective Date: ______________

❑ Changing: ❑ Beneficiary to __________ Effective Date: __________

❑ Other __________ to __________ Effective Date: __________

❑ Deleting Coverage (Explain): ______________________________

II. Employee Information

Social Security Number ______________ Occupation ______________

Last Name______________ First Name ______________ Middle Initial ______

Address ______________ City__________ County ______ State ______ Zip ______

Daytime Phone __________ Evening Phone__________ E-mail Address ______________

What is the first day you worked/rehired full-time with your current employer?______________ Hours Worked______________

Are you: ❑ Single ❑ Married, Date Married________ ❑ Divorced, Date Divorced________ ❑ Widowed, Date Widowed________

❑ Retired

❑ On COBRA Continuation - Reason______________ Start Date__________ Termination Date __________

If you or any of your dependents are entirely waiving coverage, please fill out Section IV. and VI.

III. Applicant Enrollment Information

Complete the following for all family members, beginning with you the employee, who are applying for coverage.
If additional space is needed please attach a separate sheet with completed information.

	Last Name / First Name / Middle Initial	Gender / Student Status	Relationship	Care System / Cost Tier (*Complete for Patient Choice only*)
01	**EMPLOYEE Name:** ______ Date of Birth: ____/____/____	Gender: ❑ M ❑ F		Care System: ______ Cost Tier:
02	**SPOUSE Name:** ______ Date of Birth: ____/____/____ Social Security #: ______	Gender: ❑ M ❑ F		Care System: ______ Cost Tier:
03	**Dependent Name:** ______ Date of Birth: ____/____/____ Social Security #: ______	Gender: ❑ M ❑ F Full Time Student: ❑ Y ❑ N	❑ Child ❑ Stepchild ❑ Grandchild	Care System: ______ Cost Tier:
04	**Dependent Name:** ______ Date of Birth: ____/____/____ Social Security #: ______	Gender: ❑ M ❑ F Full Time Student: ❑ Y ❑ N	❑ Child ❑ Stepchild ❑ Grandchild	Care System: ______ Cost Tier:
05	**Dependent Name:** ______ Date of Birth: ____/____/____ Social Security #: ______	Gender: ❑ M ❑ F Full Time Student: ❑ Y ❑ N	❑ Child ❑ Stepchild ❑ Grandchild	Care System: ______ Cost Tier:

IV. Coverage Options

Please check the coverage(s) you are applying for below. Availability of coverage(s) is based on your group's plan of insurance.
If anyone named in this application is waiving/declining coverage, please complete Section VII.

Type of Coverage	Applying For		Waiving/Declining this Coverage For	
Group Medical Coverage ❑ CMM Plan ❑ PPO Plan ❑ HSA Plan Please list the name of the Preferred Provider Network you choose *(if applicable)*________	❑ Myself ❑ My Dependents	❑ My Spouse	❑ Myself ❑ My Dependents	❑ My Spouse
Dental	❑ Myself ❑ My Dependents	❑ My Spouse	❑ Myself ❑ My Dependents	❑ My Spouse
Other(Please describe)	❑ Myself ❑ My Dependents	❑ My Spouse	❑ Myself ❑ My Dependents	❑ My Spouse
Vision	❑ Myself ❑ My Dependents	❑ My Spouse	❑ Myself ❑ My Dependents	❑ My Spouse
Weekly Disability	❑ Myself		❑ Myself	

V. Health Insurance and Medicare Information

A. Will you or any family member(s) continue or maintain any other health or dental insurance or self-funded group medical plan in addition to the insurance being applied for today? ❑ Yes ❑ No

B. List all health or dental insurance coverage in the last 365 days (18 months for late enrollees).
Failure to provide coverage information may result in a pre-existing condition limitation.

Name of Policyholder	Name and Address of Insurance Company / Plan	Type of Coverage (family or single)	Type of Plan (medical or dental)	Effective Date of Coverage	Cancellation Date
		❑ Family ❑ Single	❑ Medical ❑ Dental		
		❑ Family ❑ Single	❑ Medical ❑ Dental		
		❑ Family ❑ Single	❑ Medical ❑ Dental		

You have a right to request a certificate of creditable coverage from your prior plan. If necessary, we will assist you in obtaining a certificate from the prior plan. If you received a certificate of creditable coverage from your prior plan, please attach a copy to this application.

C. Are you or any of your family members eligible for Medicare? ❑ Yes ❑ No

If yes, please complete the following or attach a copy of your Medicare card.

Name of person covered by Medicare:____________________ Medicare Claim Number: ________________

Is Medicare eligibility due to: ❑ Over age 65 ❑ End-Stage Renal Disease (ESRD) ❑ Total disability

Part A Effective Date:____________ Part B Effective Date:____________ Part C Effective Date: __________

VI. Waiver of Coverage

If anyone named on this application is waiving or declining any coverage, please provide his/her name and check the reason he/she is waiving/declining:

Name(s) of person(s) waiving/declining: ______________________________

❑ I am covered or will be covered under another plan that is not sponsored by my employer. I am not enrolled for coverage under Health Insurance Risk Sharing Program (HIRSP)

❑ My dependents are covered or will be covered under another plan that is not sponsored by my employer. My dependents are not enrolled for coverage under Health Insurance Risk Sharing Program (HIRSP), Forward or Badger Care.

❑ Other: ______________________________

Waiver: I certify that I have been given the opportunity to apply for group coverage and decline to enroll as indicated on behalf of myself and/or my dependents. I understand that by signing this waiver, I and/or my dependents forfeit the right to coverage. If in the future I apply for coverage I or any of my dependents may be subject to exclusion of coverage for pre-existing conditions for a period of 18 months. This period may be offset by time covered under creditable 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 be able to enroll myself or my dependents in this plan, provided that I request enrollment within 31 days after my coverage ends. In addition, if I have a new dependent as a result of marriage, birth, adoption or placement for adoption, I understand that I may be able to enroll myself and my dependents provided that I request enrollment within 31 days after the marriage, birth or adoption. Any pre-existing waiting period that is in my policy will be offset by time served in a qualified plan.

Signature of Employee ____________________________ **Date Signed** ________________

VII. Applying for Coverage

CERTIFICATION: I represent and certify all of the following: • I am employed by the employer named herein and am working the number of hours indicated on the front of this application; • I have read and completed this entire application by myself, and that no other person, including the agent, completed any portion of this application; • 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; • I and my spouse and dependent(s) have been given the opportunity to apply for the coverage(s) available to me (us) through my employer; • and I was not pressured nor forced by my employer, the agent or the Administrator into waiving/declining any coverage as shown in Section VI. above.

UNDERSTANDING: I understand: • the representations I make, together with any supplemental representations that I make, shall be the basis for any coverage; • that no agent has the authority to waive an answer to any question, make or alter any contract, or waive or alter any of the Administrator's other rights or requirements; • that no coverage will be effective unless and until the date specified by the Administrator after this application has been approved.

I understand and acknowledge that any person who, with intent to defraud or knowledge the 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.

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"), 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 Administrator 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 regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA Privacy Regulations"), 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 Administrator to determine eligibility for coverage under my employer's plan and that my failure to authorize the release of said information may result in a refusal to issue or provide coverage. I agree that the Administrator may release said information to MIB or to the Insurer's 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 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 on 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 this authorization is 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 Regulations and could be re-disclosed by the person or entity that receives it.

Has any person assisted you in the completion of this form? ❑ **Yes** ❑ **No** **If yes, please print name:** ______________________________

Applicant's Signature ______________________________ **Date Signed** ____________________

NOTICE OF SPECIAL ENROLLMENT RIGHTS FOR HEALTH COVERAGE

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 towards your or your dependents' 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. In addition, if a claim is denied because a person has reached a lifetime limit on benefits, Health Insurance Portability and Accountability Act (HIPAA) regulations deem that to be a loss of eligibility for coverage for special enrollment purposes.

However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your 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:

MEMBER SERVICES DEPARTMENT
SUPERVISOR ADMINISTRATIVE OPERATIONS
TELEPHONE NUMBER: 1-800-748-0575

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