



2012 Special Enrollment
 Dental - Graded Max Benefit
 1st Yr \$500, 2nd \$750, 3rd \$1,000
 Orthodontia - 24 Mo. Waiting Period

EPIC BENEFITS+ ENROLLMENT FORM

Underwritten by The EPIC Life Insurance Company

Please print clearly or type - Submit completed form to your payroll/benefits office

Section 1: Applicant Information

Applicant name (last, first, middle)		Spouse/Domestic Partner Name (last, first, middle)	
Street Address (street, city, state, zip code)			
Daytime Telephone Number ()	Date of Birth (MM/DD/CCYY)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security number/EPIC Benefits+ ID No.

Section 2: Enrollment Information - Limited Term Employees must complete six months of WRS employment before enrolling.

Reason for Application (Check one):	<input type="checkbox"/> New Hire	<input type="checkbox"/> Transfer	<input type="checkbox"/> Coverage Change	<input type="checkbox"/> Approved Enrollment Period
	<input type="checkbox"/> Spouse to Spouse or Domestic Partner to Domestic Partner Coverage Transfer			<input type="checkbox"/> Cancel Coverage
	<input type="checkbox"/> Address Change	<input type="checkbox"/> Name Change	<input type="checkbox"/> Beneficiary Change	
Plan (Check one):	<input type="checkbox"/> Without Vision Insurance	Coverage Level:	<input type="checkbox"/> Employee	<input type="checkbox"/> Employee + Spouse/Domestic Partner
	<input type="checkbox"/> With Vision Insurance		<input type="checkbox"/> Employee + Child	<input type="checkbox"/> Family

Section 3: List Spouse/Domestic Partner/Child(ren) to be enrolled (use additional paper if needed to list all dependents)

Name	Date of Birth (MM/DD/CCYY)	Gender (M/F)	Social Security Number	Relationship to Applicant	Disabled (Y/N)	Tax Dep (Y/N)	Married (Y/N)

Beneficiary:	Last Name	First Name	Middle Initial	Relationship
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Section 4: Change/Add/Cancel Current Coverage

Subscriber Name Change to:			
Add/Change Coverage Due to: <i>(list dependents you are adding in Section 3)</i>	Date	Cancel/Change Coverage Due to: <i>(list dependents you are adding in Section 3)</i>	Date
<input type="checkbox"/> Marriage		<input type="checkbox"/> Divorce/Termination of Domestic Partnership	
<input type="checkbox"/> Domestic Partnership Established		<input type="checkbox"/> Death of Spouse/Partner/Child	
<input type="checkbox"/> Addition of Children (qualifying event)		<input type="checkbox"/> Loss of Dependent Eligibility	
<input type="checkbox"/> Other Change:	Explanation if Needed:		

Section 5: Information about Other Coverage (complete for all family members enrolling)

I have the following group insurance or had the following group insurance immediately prior to the anticipated effective date of this coverage: State of Wisconsin Group Health Insurance Name of Health Plan: _____
 Other Insurance: Type of Coverage: Health Dental Name(s) of All Other Plan(s): _____

My dependent(s) has other group coverage through an employer or had the following group insurance immediately prior to the anticipated effective date of this coverage: Yes No If yes, name of dependent(s): _____
 State of Wisconsin Group Health Insurance Name of Health Plan: _____
 Other Insurance: Type of coverage: Health Dental Name(s) of All Other Plan(s): _____

Section 6: Signature - (Sign here and return completed application to your employer)

I apply for the coverage elected above. I understand that Wis. Stats. §943.395 provides criminal penalties for knowingly making false or fraudulent claims on this form and hereby certify that, to the best of my knowledge and belief, the information is true and correct. I agree to the provisions of the plan and hereby authorize deduction of the monthly premium from my salary. I understand that once enrolled this coverage must remain in force for the full calendar year unless eligibility is lost.

I do not wish to enroll at this time

Cancel my coverage as of December 31, _____. I understand that I must submit the application to cancel coverage by December 1 or coverage will remain in force for the following calendar year unless eligibility is lost.

Applicant Signature X	Date (MM/DD/CCYY)
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For Office Use Only

Date Rec'd	Received by	Hire Date	Cov Eff Date	Agency/Campus Code	Ded. Code - UW only <input type="checkbox"/> 487 <input type="checkbox"/> 488
Affidavit of domestic partnership on file <input type="checkbox"/> N/A <input type="checkbox"/> ETF Affidavit <input type="checkbox"/> Non "Chapter 40" Affidavit				Premium \$	Employee ID - UW Only