

# INDIVIDUAL POLICY CHANGE APPLICATION

Mail This Application To:  
Wisconsin Physicians Service Insurance Corporation  
P.O. Box 7898—Madison, WI 53707



**INSTRUCTIONS:** Please complete the entire application. Please print using black ink. WPS 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.

Customer Number \_\_\_\_\_

Social Security Number \_\_\_\_\_ Policy Number \_\_\_\_\_

Where would you like your policy delivered?  Applicant  Agent

## 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: \_\_\_\_\_

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

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

- a. Deductible: Current Deductible: \_\_\_\_\_  
Change to:  \$250  \$500  \$1,000  \$1,500  \$2,500  \$5,000  \$7,500  
Drug: If you selected the \$250, \$500, \$1,000 or \$1,500 deductible option, choose one of the following:  
 \$15/\$40/\$60 copay  \$500 deductible, then \$15/\$40/\$60  
If you selected the \$2,500, \$5,000 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  
 80%/60% of the next \$5,000  80%/60% of the next \$10,000

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

- a. Current Preferred Plan Deductible: \_\_\_\_\_  
Change Deductible to: (choose one)  
 \$1,100 Single, \$2,200 Family  \$1,500 Single, \$3,000 Family  
 \$2,000 Single, \$4,000 Family  \$2,850 Single, \$5,650 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 \$1,100/\$2,200 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)  
 \$1,100 Single, \$2,200 Family  \$1,500 Single, \$3,000 Family  
 \$2,000 Single, \$4,000 Family  \$2,850 Single, \$5,650 Family  
 \$3,500 Single, \$7,000 Family  \$5,500 Single, \$11,000 Family

## 1. Information Changes (cont'd.)

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

Change Coinsurance to: (choose one)

100%/80%

90%/70%\*

80%/60%\*\*

\*Only available on the \$1,100/\$2,200 deductible option

\*\*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:  \$250  \$500  \$1,000  \$1,500  \$2,500  \$5,000  \$7,500

Drug: If you selected the \$250, \$500, \$1,000 or \$1,500 deductible option, choose one of the following:

\$15/\$40/\$60 copay

\$500 deductible, then \$15/\$40/\$60

If you selected the \$2,500, \$5,000 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

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

If you are increasing your deductible (example \$250 to \$500) 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 the WPS Underwriting Department in Madison, Wisconsin.

If you are decreasing your deductible (example \$500 to \$250) and/or raising your coinsurance (example 80% to 90%), you and your covered dependents are subject to our health underwriting requirements. You must complete Section 2. If WPS approves the change you are requesting, the effective date of the change will be assigned by WPS as stated in Section 3.

### 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 the WPS Underwriting Department in Madison, Wisconsin. **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.

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.**

### G. CHANGING FROM SINGLE COVERAGE TO ANOTHER COVERAGE

Change from single coverage to:  Applicant and Spouse Coverage  Applicant and Child(ren) Coverage

Applicant, Spouse, and Child(ren) Coverage

Coverage Change due to:

Adding Newborn Child Newborn's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Last

First

Middle Initial



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

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

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

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

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

**J. CHANGING DEPENDENT STATUS**

Add Dependent as Full-Time Student:

Name of Dependent Child \_\_\_\_\_

Date Enrollment Began \_\_\_\_\_

Is this dependent not providing 50% or more of his/her own support?  Yes  No

Terminate Dependent Child as Full-Time Student:

Name of Dependent Child \_\_\_\_\_

Date of Graduation or Termination of College/University Enrollment \_\_\_\_\_

**K. OTHER CHANGE**

If a requested change is other than a change listed in Subsections A through J above, please explain below and **complete Sections 2 and 4.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**2. INFORMATION ABOUT YOU AND YOUR FAMILY'S HEALTH • ANY MISREPRESENTATION MAY BE USED TO DENY A CLAIM OR TO RESCIND AND VOID THE POLICY. Please do not include any AIDS virus antibody tests, except for the FDA licensed blood tests taken and diagnosed by a member of the medical profession. Any tests performed at anonymous counseling and testing sites or through home test kits are confidential and need not be revealed on this application.**

The following questions must be answered either "Yes" or "No." Please provide full details on page 6 for each "Yes" answer.

- A. Are you, your spouse or any dependent pregnant or an expectant mother or father (even if dependent coverage is not being requested)? .....  Yes  No
- B. Have you, your spouse or any dependent applying for coverage smoked cigarettes or used tobacco or nicotine in any form including smokeless tobacco within the past 12 months? .....  Yes  No
- C. Have you, your spouse or any dependent applying for coverage been diagnosed or been treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), diseases associated with AIDS, or other immune system disorders, or ever tested positive for antibodies to the Human Immunodeficiency Virus (HIV)? .....  Yes  No
- D. Have you, your spouse or any dependent applying for coverage ever had symptoms of or been treated for alcohol, substance or drug abuse or dependence; ever been advised to limit or reduce the use of alcohol, chemicals, or other drugs; had any alcohol or drug-related arrest; or been a member of Alcoholics Anonymous? .....  Yes  No
- E. In the past 10 years, have you, your spouse or any dependent applying for medical, disability or life insurance with any company ever been declined for coverage; had coverage postponed or ridered, whether or not a policy was issued; or had a premium increase due to health history? .....  Yes  No
- F. Is anyone named in this application now disabled or unable to perform normal work- or age-related activities?.....  Yes  No  
If Yes, please identify names, conditions, dates of disability, and name and address of physician.

**2. Information About You and Your Family's Health (cont'd.)**

G. **In the past 10 years** have you, your spouse or any dependent applying for coverage had symptoms of, been diagnosed, treated (including chiropractic treatment), or sought a medical opinion for any of the following, even if you no longer have any current symptoms:

- |   |  |  |  |
|---|--|--|--|
| 1. Heart disease or disorder .....  | <input type="checkbox"/> Yes <input type="checkbox"/> No | 44. Cancer .....   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Stroke .....   | <input type="checkbox"/> Yes <input type="checkbox"/> No | 45. Tumor.....   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Circulatory disease or disorder.....   | <input type="checkbox"/> Yes <input type="checkbox"/> No | 46. Cyst .....   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Chest pain .....   | <input type="checkbox"/> Yes <input type="checkbox"/> No | 47. Polyp .....  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. High or low blood pressure .....   | <input type="checkbox"/> Yes <input type="checkbox"/> No | 48. Abnormal growth.....                                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Elevated cholesterol and/or triglyceride levels.....                           | <input type="checkbox"/> Yes <input type="checkbox"/> No | 49. Carcinoma in situ.....                                 | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Anemia or blood disease or disorder .....                                      | <input type="checkbox"/> Yes <input type="checkbox"/> No | 50. Eye disease or disorder .....                          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Ulcers .....   | <input type="checkbox"/> Yes <input type="checkbox"/> No | 51. Ear disease or disorder.....                           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Stomach disease or disorder.....   | <input type="checkbox"/> Yes <input type="checkbox"/> No | 52. Attention deficit disorder.....                        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Liver/pancreas disease or disorder .....                                      | <input type="checkbox"/> Yes <input type="checkbox"/> No | 53. Psychological disease or disorder .....                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 11. Gallbladder disease or disorder .....   | <input type="checkbox"/> Yes <input type="checkbox"/> No | 54. Depression .....                                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 12. Intestinal disease or disorder (e.g., colitis, Crohn's)                       | <input type="checkbox"/> Yes <input type="checkbox"/> No | 55. Anxiety.....   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 13. Hernia .....  | <input type="checkbox"/> Yes <input type="checkbox"/> No | 56. Nervous, mental or emotional disorder .....            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 14. Rectal disease or disorder.....   | <input type="checkbox"/> Yes <input type="checkbox"/> No | 57. Suicide attempt .....                                  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 15. Diabetes.....   | <input type="checkbox"/> Yes <input type="checkbox"/> No | 58. Eating disorder.....                                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 16. Elevated blood sugar.....   | <input type="checkbox"/> Yes <input type="checkbox"/> No | 59. Epilepsy or other seizures .....                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 17. Sugar albumin or blood in urine.....  | <input type="checkbox"/> Yes <input type="checkbox"/> No | 60. Convulsions .....                                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 18. Thyroid disease or disorder .....   | <input type="checkbox"/> Yes <input type="checkbox"/> No | 61. Headaches .....  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 19. Adrenal disease or disorder .....   | <input type="checkbox"/> Yes <input type="checkbox"/> No | 62. Nervous System disease or disorder .....               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 20. Enlargement of the lymph nodes .....  | <input type="checkbox"/> Yes <input type="checkbox"/> No | 63. Organ or other type of transplant.....                 | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 21. Connective tissue disease or disorder.....                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | 64. Breast disease or disorder incl. fibrocystic breast(s) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 22. Allergy(ies) .....  | <input type="checkbox"/> Yes <input type="checkbox"/> No | 65. Sleep Disorder .....                                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 23. Asthma .....  | <input type="checkbox"/> Yes <input type="checkbox"/> No | 66. Sleep Apnea .....                                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 24. Hayfever .....  | <input type="checkbox"/> Yes <input type="checkbox"/> No | 67. Lupus .....  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Emphysema.....  | <input type="checkbox"/> Yes <input type="checkbox"/> No | 68. Arthritis .....  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 26. Sinus or nasal disease or disorder.....                                       | <input type="checkbox"/> Yes <input type="checkbox"/> No | 69. Fibromyalgia .....                                     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 27. Lung disease or disorder.....   | <input type="checkbox"/> Yes <input type="checkbox"/> No | 70. Back disorder .....                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 28. Shortness of breath .....   | <input type="checkbox"/> Yes <input type="checkbox"/> No | 71. Joint disorder .....                                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 29. Pneumonia.....  | <input type="checkbox"/> Yes <input type="checkbox"/> No | 72. Musculoskeletal disease or disorder .....              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 30. Menstrual disease or disorder .....   | <input type="checkbox"/> Yes <input type="checkbox"/> No | 73. Skin disease or disorder.....                          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 31. Genital disease or disorder .....   | <input type="checkbox"/> Yes <input type="checkbox"/> No | 74. Acne .....   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 32. Sexual dysfunction .....  | <input type="checkbox"/> Yes <input type="checkbox"/> No | 75. Throat disease or disorder .....                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 33. Infertility .....   | <input type="checkbox"/> Yes <input type="checkbox"/> No | 76. Paralysis.....   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 34. Urinary tract disease or disorder.....  | <input type="checkbox"/> Yes <input type="checkbox"/> No | 77. Spinal Cord disorder .....                             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 35. Kidney disease or disorder .....  | <input type="checkbox"/> Yes <input type="checkbox"/> No | 78. Chronic fatigue syndrome .....                         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 36. Bladder disease or disorder.....  | <input type="checkbox"/> Yes <input type="checkbox"/> No | 79. Hepatitis .....  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 37. Prostate disease or disorder .....  | <input type="checkbox"/> Yes <input type="checkbox"/> No | 80. Multiple sclerosis.....                                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 38. Abnormal Prostate Specific Antigen (PSA) results                              | <input type="checkbox"/> Yes <input type="checkbox"/> No | 81. Disease or disorder of brain.....                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 39. Disease or disorder of male or female sex organs ..                           | <input type="checkbox"/> Yes <input type="checkbox"/> No | 82. Any type of implant.....                               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 40. Abnormal Pap smear results.....   | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |  |
| 41. Abnormal mammogram results .....  | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |  |
| 42. Sexually transmitted disease or disorder .....                                | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |  |
| 43. Pregnancy complications (e.g., premature birth, miscarriage, c-section) ..... | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |  |

H. **In the past five years** have you, your spouse or any dependent applying for coverage:

1. Been hospitalized or scheduled for hospitalization; had surgery or surgery scheduled; had a test or test scheduled; or been recommended to have a test, treatment, or surgery which was not performed?.....  Yes  No
2. Had an injury, accident, illness, medical attention, diagnosis, or treatment for any reason not already mentioned (except AIDS, HIV and genetic testing results)? .....
3. Consulted with or been treated by any physicians or other health care professionals (including chiropractors, podiatrists and osteopathic physicians) for any reason other than stated above? .....

I. Are you, your spouse or any dependent applying for coverage currently taking any medications recommended or prescribed by a physician or other health care practitioner? .....

If Yes, please list all medications and their dosage in the space provided on page 6.  Yes  No

J. Have you, your spouse or any dependent applying for coverage had a medication recommended or prescribed by a physician or other health care practitioner within the past 12 months?.....  Yes  No

If Yes, please list all medications and their dosage in the space provided on page 6.

**GIVE DETAILS BELOW OF ANY “YES” ANSWERS TO QUESTIONS A.–H. IF MORE SPACE IS NEEDED, PLEASE ATTACH AN ADDITIONAL SHEET OF PAPER; PLEASE SIGN AND DATE THE ADDITIONAL SHEET.**

Question	Name of Person	Illness or Health Condition <i>(Include diagnosis and prognosis)</i>	Dates Treated		Complete Name and Address of Physician Clinic, Hospital or Other Provider
			Beginning	Ending <i>(Indicate if ongoing)</i>	

**GIVE DETAILS BELOW OF ANY “YES” ANSWERS TO QUESTIONS I. & J. IF MORE SPACE IS NEEDED, PLEASE ATTACH AN ADDITIONAL SHEET OF PAPER; PLEASE SIGN AND DATE THE ADDITIONAL SHEET.**

Question	Name of Person	Name, Dosage and Frequency of Medication <i>(Include illness or health condition for which medication was prescribed)</i>	Dates Medication Taken <i>(Indicate if ongoing)</i>	Complete Name and Address of Prescribing Physician and Pharmacy

**3. 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 WPS, **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 and year.)

**4. 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; • 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 WPS 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 WPS' other rights or requirements; • that no coverage will be effective unless and until the date specified by WPS after this application has been approved by WPS; • 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 WPS' acceptance of the risk, including approving any person for coverage.

I understand that WPS 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 WPS, 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 WPS 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 WPS.

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.**

<p><i>(Please sign in black ink.)</i></p> <div style="display: flex; align-items: center; margin-top: 20px;"> <div style="text-align: center; margin-right: 20px;"> <p><b>Sign Here</b></p>  </div> <div style="border-bottom: 1px solid black; width: 100%;"></div> </div> <div style="margin-top: 10px;"> <div style="border-bottom: 1px solid black; width: 100%;"></div> <div style="border-bottom: 1px solid black; width: 100%;"></div> <div style="border-bottom: 1px solid black; width: 100%;"></div> </div>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="height: 30px;"> </td></tr> <tr><td style="text-align: center;">Date</td></tr> <tr><td style="height: 30px;"> </td></tr> <tr><td style="text-align: center;">Date</td></tr> <tr><td style="height: 30px;"> </td></tr> <tr><td style="text-align: center;">Date</td></tr> </table>		Date		Date		Date
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**5. 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) \_\_\_\_\_

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

Street Address \_\_\_\_\_ Agent's Fax # \_\_\_\_\_

City \_\_\_\_\_ Date Signed by Agent \_\_\_\_ / \_\_\_\_ / \_\_\_\_

State/Zip \_\_\_\_\_ Agent's Social Security Number \_\_\_\_\_

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


## 6. 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"), consumer reporting agency, or other organization, institution, or person that has any record or knowledge of me or my minor children to give to Wisconsin Physicians Service Insurance Corporation ("WPS") 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 WPS 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 WPS 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 WPS at its office in Madison, Wisconsin, and that any information released in reliance upon 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 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.

<p><i>(Please sign in black ink.)</i></p> <p><b>Sign Here</b> </p>	_____	_____
	Applicant's Signature	Date
	Spouse's Signature	Date
_____	_____	_____
Child Over Age 18's Signature	Date	

**CREDIT/DEBIT CARD AUTHORIZATION FORM**

**A. Applicant Information**

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

WPS Customer Number (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 Must be from a personal account	_____ / _____ Card Expiration Date	_____ Credit/Debit Verification Number (This number is located on the back of your credit/debit card. It's the three-digit number found after your card number.)
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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.

*(Please sign in black ink.)*

**Sign Here**  **X** \_\_\_\_\_

Applicant's Signature

\_\_\_\_\_

Date

**FINANCIAL INFORMATION**

**AUTOMATIC WITHDRAWAL PAYMENT AUTHORIZATION FORM**

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

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

*(Please sign in black ink.)*  
**Sign Here**  **X** \_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

**FINANCIAL INFORMATION**