



**WISCONSIN PHYSICIANS SERVICE INSURANCE CORPORATION
ENROLLMENT FORM FOR STUDENTS AND THEIR DEPENDENTS**



INSTRUCTIONS: Please complete the entire application. Please print using **black ink**. **Milwaukee School of Engineering**

1. Reason for Application

Please indicate if you are:

- Full Time Student
 Part-Time Student
 Graduate Student
 Other – Accelerated Programs
 Applying for Family Coverage
 Applying for Continuation Coverage
 Adding a Dependent:
 Name _____ Effective Date: _____
 Addition Due To:
 Marriage - Date _____
 Birth - Date _____
 Addition Due To:
 Adoption - Date _____
 Other/Date _____

2. Information About You (Applicant)

Student Name: _____ Social Security No: _____ Student ID: _____
Last First
 Gender: Male Female
 Date of Birth: _____ Expected Date of Graduation: _____
Month Year
 Permanent Address: _____
Number & Street City State Zip County
 Mailing Address: _____
Number & Street City State Zip County
 Telephone Number: _____ E-Mail Address: _____

3. Information About Your Family (If enrolling dependents, please complete this section)

Last Name	First Name	MI	Gender	Birth Date	Relationship to Applicant

4. Payment Information

Charge Full Amount: _____
 Visa: _____ MasterCard: _____
 Expiration Date: _____
 Authorized Signature: _____ Date: _____

OR

Paid by Check Number: _____ Amount Paid: _____

Make check or money order payable to WPS or refer to the charge card authorization above to charge your premium to Visa or MasterCard.
 Mail this enrollment form along with premium payment to: **WPS Health Insurance**
P.O. Box 8190 • Madison, WI 53708-8190

Your cancelled check or credit card billing is your only receipt and notification of coverage. **It is the student's responsibility for timely renewal payments whether or not a renewal notice is received.**

5. Notice to Student/Signature

Coverage will be effective the date the correct premium is received by the Insurer or a representative of the Insurer or the effective date of the coverage period, whichever is later. By signing, the student acknowledges the following: (1) he/she has carefully read the brochure and elects to enroll as indicated on this enrollment form; (2) rates are not pro-rated other than as listed on this enrollment form; (3) he/she meets the eligibility requirements for this coverage as described in the brochure; and (4) if it is later determined that the student is not eligible, the premium will be refunded and coverage will not be in effect. **Premium will not be refunded except for ineligibility or entrance into the armed forces.**

I understand the policy is not renewable. I further understand and agree that the Insurer, its directors, officers, employees, and agents shall not be liable for any injury, damage, or expense (including attorney's fees) I, my spouse or any dependent(s) suffer as a result of any improper advice, action, or omission on the part of any health care provider.

Student's Signature: _____ Date: _____

6. Coverage Election – Please Check All Appropriate Boxes

Effective/Expiration Periods: Annual 8-01-2011 to 7-31-2012
 First Quarter 8-01-2011 to 11-27-2011
 Second Quarter 11-28-2011 to 3-04-2012
 Third Quarter 3-05-2012 to 5-26-2012
 Fourth Quarter 5-27-2012 to 7-31-2012

Voluntary Premiums:	Annual	First Quarter	Second Quarter	Third Quarter	Fourth Quarter
Student	<input type="checkbox"/> \$1,380.00	<input type="checkbox"/> \$449.92	<input type="checkbox"/> \$366.74	<input type="checkbox"/> \$313.81	<input type="checkbox"/> \$249.53
Spouse	<input type="checkbox"/> \$3,105.00	<input type="checkbox"/> \$1,012.32	<input type="checkbox"/> \$825.16	<input type="checkbox"/> \$706.07	<input type="checkbox"/> \$561.45
Dep. Child	<input type="checkbox"/> \$2,415.00	<input type="checkbox"/> \$787.36	<input type="checkbox"/> \$641.79	<input type="checkbox"/> \$549.16	<input type="checkbox"/> \$436.68

International Premiums	Annual	First Quarter	Second Quarter	Third Quarter	Fourth Quarter
Spouse	<input type="checkbox"/> \$2,385.00	<input type="checkbox"/> \$777.58	<input type="checkbox"/> \$633.82	<input type="checkbox"/> \$542.34	<input type="checkbox"/> \$431.26
Dep. Child	<input type="checkbox"/> \$1,855.00	<input type="checkbox"/> \$604.78	<input type="checkbox"/> \$492.97	<input type="checkbox"/> \$421.82	<input type="checkbox"/> \$335.42

Monthly Continuation: Student \$172.50 Spouse \$388.13 Dep. Child \$301.88

To calculate your continuation rate, multiply the monthly rate stated above times the number of months purchased.

Number of months purchased _____.

7. Information About Other Medical Coverage

Will you or any family member(s) continue or maintain any other health coverage in addition to the insurance being applied for today?
 No Yes

List all coverage in the last 270 days. Failure to provide coverage information may result in a pre-existing condition limitation.

Policyholder Information	Name, Address and Phone Number of Insurance Company / Plan	Policy or Group Number	Type of Coverage	Type of Plan	Effective Date of Coverage	Cancellation Date
Name: <input type="checkbox"/> Employee <input type="checkbox"/> Spouse Date of Birth:			<input type="checkbox"/> Family <input type="checkbox"/> Single	<input type="checkbox"/> Medical <input type="checkbox"/> Dental		
Name: <input type="checkbox"/> Employee <input type="checkbox"/> Spouse Date of Birth:			<input type="checkbox"/> Family <input type="checkbox"/> Single	<input type="checkbox"/> Medical <input type="checkbox"/> 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 enrollment form.