

INSTRUCTIONS FOR COMPLETING HEALTH INSURANCE APPLICATION/CHANGE FORM

SECTION 1 – APPLICANT INFORMATION

1. *Print* your responses *clearly* and *legibly*.
 2. Enter your complete name (including your previous name, if applicable), your Social Security Number (SSN), your home address, including the county, and your home and daytime telephone numbers in the spaces provided.
- NOTE: If you choose not to enroll, go to Section 7.
3. Marital or Domestic Partnership Status: Check the box that applies to you. If you indicate that you are Married, Divorced, Widowed, or in a Domestic Partnership, list the date in the space provided. *Note the effective date of a Domestic Partnership is the date that ETF receives the Affidavit of Domestic Partnership form (ET-2371).* If married or in a domestic partnership, you must provide your spouse/domestic partner name, SSN and birth date, even if you are applying for single coverage.
 4. Eligibility Status: Check one box which describes your status as an applicant.
 5. For initial enrollment only, indicate if you want immediate health insurance coverage or coverage when you become eligible for the employer contribution toward the health insurance premium. Indicate It's Your Choice enrollment for coverage changes during the annual enrollment period.
 6. Coverage Desired: Indicate level of coverage desired by checking either single or family.
 7. Health Plan Selected: Indicate the name of the Health Plan that you want to provide your health insurance.

SECTION 2 – REASON FOR APPLICATION

Subsections A and B

1. Indicate the reason for submitting this application by checking the box(es) that apply. If selecting Change To Single Coverage or Spouse To Spouse Transfer, you must also indicate the reason for your request.
2. If checking boxes in Subsection A only or both A and B, go to Section 3 and complete all enrollment information.
3. If checking boxes in Subsection B only, go to Section 7 to complete the application; except if you are updating Other Insurance Coverage, complete Section 6 & 7.

Changes To Dependent Coverage

Subsection C

Complete this Subsection when deleting a dependent. Check the reason and list all dependents to be deleted from your Health Insurance Contract. Use "Other" box, for example, to disenroll adult children during the annual It's Your Choice period.

Go to Section 7 to complete the application.

Subsection D

Complete this Subsection when adding a dependent. Check the reason for adding a dependent(s) and indicate the event date. Use the "Other" box to add eligible dependents for an unlisted reason. See Terms & Conditions #5 for more information. Go to Section 3 and list all family members who are being added to your Health Insurance Contract. Also, complete Sections 4, 5, 6 and 7.

SECTION 3 – ENROLLMENT INFORMATION

Provide all information requested in this Section for yourself, when applying for single coverage; when applying for family coverage, list yourself and all eligible dependents.

If the SSN is not known because it was just applied for, write "APPLIED FOR" in that field.

For "Rel. Code," use the following codes to describe the relationship of dependents to you:

01=Spouse	24=Dependent of Your Minor Child
15=Legal Ward	53=Domestic Partner
17=Stepchild	38=Dependent of Domestic Partner
19=Child	

Completion of the Marital Status column is required. Indicate "Yes" for married or "No" for not married.

Indicate "Yes" or "No" if the dependent is disabled.

Indicate "Yes" or "No" if any dependent over age 27 is disabled.

Indicate "Yes" or "No" if your domestic partner and/or dependent child is considered a "tax dependent" under federal law. You do not need to complete this box for your spouse. *Note there may be tax consequences to you when you cover dependents (i.e., domestic partners and children) who are not dependent on you for at least 50% of their support.*

For yourself and all eligible dependents, provide the name of the physician or clinic. If selecting the Standard Plan, indicate "NONE."

SECTION 4 – ADDITIONAL INFORMATION

Indicate "Yes" or "No" for all three questions, and list names as applicable.

SECTION 5 – MEDICARE INFORMATION

Indicate whether any of your dependents (including your spouse/domestic partner) are covered by Medicare, and list the names of those covered. Provide the Health Insurance Claim number (HIC#) and effective date from the Medicare card for any individuals covered by Medicare.

SECTION 6 – "OTHER COVERAGE"

Provide information regarding any other group *health insurance* under which you or your dependents (including your spouse/ domestic partner) are covered. NOTE: "Other coverage" does not include supplemental insurance (examples, EPIC or DentalBlue).

SECTION 7 – SIGNATURE

Read the **TERMS AND CONDITIONS** on the back of this page.

1. If applying for health insurance coverage, check the box that you are applying for coverage, sign and date the application, indicating agreement with the terms and conditions. Submit the application to your payroll representative or to ETF if you are an annuitant/continuant.
2. If declining health insurance coverage, check the box indicating you do not wish to enroll, sign and date the application, and submit to your payroll representative.
3. If cancelling current health insurance coverage, check the box indicating you wish to cancel coverage. Also, check one of the four boxes following that indicates if employee premiums are deducted pre-tax or post-tax and if you do or do not have comparable coverage or if your required contribution has significantly increased. The earliest your coverage will end when indicating if employee premiums are deducted pre-tax and you do not have comparable coverage is the end of the current year, 12/31/XXXX. Sign and date the application then submit it to your payroll representative.
4. Your employer will complete Section 8 and provide a copy of the application to you. For annuitants/continuant, ETF will complete section 8 and provide a copy of the application to you.
5. If submitting during the annual It's Your Choice enrollment period, make a copy for your records.

ETF Use Only

State of Wisconsin
Department of Employee Trust Funds
HEALTH INSURANCE APPLICATION/CHANGE FORM

Employer Notes

1. APPLICANT INFORMATION

Applicant - Last Name, First, Middle, Previous Name, Social Security Number
Address - Street and No., City, State, Zip Code
County, Country (if not USA), Home Telephone No., Daytime Telephone No.

MARITAL OR DOMESTIC PARTNERSHIP STATUS: Single, Married, Divorced, Widowed, Domestic Partnership
Spouse/Domestic Partner Name, SSN, Birth Date

ELIGIBILITY STATUS (check one) Employee, Survivor, Continuant (COBRA), Annuitant, Graduate Assistant
I WANT MY COVERAGE TO BE EFFECTIVE: As soon as possible, When employer contributes premium, It's Your Choice (January 1)

COVERAGE DESIRED Single, Family
HEALTH PLAN SELECTED

2. REASON FOR APPLICATION

A. Check all boxes that apply. Go to Section 3. Initial Enrollment, Moved from Service Area, Change to Family Coverage, Change to Single Coverage, Spouse/DP to Spouse/DP Transfer, Transfer from One State Agency to Another, COBRA, It's Your Choice, Other.
B. Check all boxes that apply. Cancellation, Name Change, Address Change, Telephone Number Change, Social Security Number Correction.
C. Complete the following for deleting a dependent. List only dependents affected by this change below. Reason: Divorce/DP terminated, Age*, Dependent Married, Other.

1 If premiums are pre-tax, change to single coverage allowed only when your last dependent becomes ineligible for coverage.
2 If premiums are pre-tax, mid-year transfer allowed only when spouse carrying coverage terminates employment, goes on unpaid LOA, or drops to less than half-time employment.

Table with columns: Last Name, First, Middle, Birthdate (Mo, Day, Yr), Gender (M/F), Social Security Number, Event Date, Dependent's Address (if different than subscriber's)

NOTE: THE DELETION OF A DEPENDENT DUE TO LOSS OF ELIGIBILITY PROVIDES AN OPPORTUNITY FOR CONTINUATION COVERAGE (COBRA) UP TO 36 MONTHS PROVIDED NOTICE IS GIVEN TO THE EMPLOYER WITHIN 60 DAYS OF EVENT

D. Complete the following when adding a dependent. List only dependents affected by this change in Section 3. Reason: Marriage, Birth, Legal Ward, Adoption, Domestic Partner, Disabled, Other. Event Date.
**Please attach documentation for additions due to legal ward, adoption, paternity, National Medical Support Notice, or loss of coverage; acknowledgement to ETF affidavit required for domestic partnership.

Dependents include spouse or domestic partner and children under age 27. Children include those who are your natural children, legal wards who become your permanent ward prior to age 19, adopted children, stepchildren, children of your domestic partner, or grandchildren until the grandchildren's parent (your child) reaches age 18.

Applicant Name _____ Social Security Number _____

3. ENROLLMENT INFORMATION				Gender (M/F)	Social Security Number	Rel. Code	Marital Status	Disabled? (Y/N)	Tax Dep? (Y/N)	Select Physician or Clinic
Last Name	First	Middle	Previous							
Applicant										
Spouse/Domestic Partner										
Dependent Children										

4. ADDITIONAL INFORMATION

a. Are any of the dependents listed above your grandchild? Yes No If yes, name of parent _____

5. MEDICARE INFORMATION

Are you or any insured dependent covered under Medicare? Yes No If yes, list names of insured and Medicare dates.

Name: _____ Dates: Part A _____ Part B _____ HIC # _____

Name: _____ Dates: Part A _____ Part B _____ HIC # _____

6. OTHER COVERAGE ^A

a. Other health insurance coverage? Yes No If yes, name of other insurance company _____
Name(s) of Insured(s) _____

b. Is your spouse/domestic partner a State of Wisconsin employee or annuitant (including University of Wisconsin)? Yes No

7. SIGNATURE (read the Terms and Conditions on the attached page, check one box and sign)^A

I apply for the insurance under the indicated health insurance contract made available to me through the State of Wisconsin and have read and agree to the **TERMS AND CONDITIONS**. A copy of this application is to be considered as valid as the original.

I do not wish to enroll at this time.

I wish to cancel my current coverage. My employee premium is deducted (Please check one box.):

- pre-tax and I acknowledge that I have comparable coverage.
- pre-tax and my required contributions has significantly increased.
- pre-tax and I do not have comparable coverage. Coverage will end 12/31/XXXX.
- post-tax.

To the best of my knowledge, all statements and answers in this application are complete and true. All information is furnished under penalty of Wis. Stat. § 943.395. Additional documentation may be required by ETF at any time to verify eligibility

SIGN HERE & Return to Employer <input checked="" type="checkbox"/>	Date Signed (MM/DD/CCYY)	Applicant Signature

8. EMPLOYER COMPLETES (Coding Instructions are in the Employer Health Insurance Administration Manual)							
Employer Number 69-036-	Name of Employer				Program Option Code	Surcharge Code	
Group Number	Enrollment Type A	Employee Type	Coverage Type Code	Carrier Suffix	Standard Plan Waiting Period	Participant County Code	
Previous Service – Complete Information			Date Application Received by Employer (MM/DD/CCYY)	Date WRS Eligible Employment Began or Graduate Assistant Appointment Began (MM/DD/CCYY)			
1. Did employee participate under WRS prior to being hired by you? <input type="checkbox"/> Yes <input type="checkbox"/> No							
2. Previous service check completed? <input type="checkbox"/> Yes <input type="checkbox"/> No							
3. Source of previous service check: <input type="checkbox"/> Online Network for Employers(ONE) <input type="checkbox"/> ETF							
Monthly Employee Share \$	Monthly Employer Share \$		Event Date (MM/DD/CCYY)		Prospective Date of Coverage (MM/DD/CCYY)		
Payroll Representative Signature				Telephone ()			

COPY AND DISTRIBUTE: ETF EMPLOYEE EMPLOYER

HEALTH INSURANCE APPLICATION/CHANGE FORM TERMS AND CONDITIONS

1. To the best of my knowledge, all statements and answers in this application are complete and true. I understand that if I provide false or fraudulent information on this application, I may face criminal charges/sanctions under Wis. Stat. § 943.395.
2. I authorize the Department of Employee Trust Funds (ETF) to obtain any information from any source necessary to administer this insurance.
3. I agree to pay in advance the current premium for this insurance, and I authorize my employer (the remitting agent) to deduct from my wages or salary an amount sufficient to provide for regular premium payments that are not otherwise contributed. The remitting agent shall send the premium on my behalf to ETF.
4. I understand that eligibility for benefits may be conditioned upon my willingness to provide written authorization permitting my health plan and/or ETF to obtain medical records from health care providers who have treated me or any dependents. If medical records are needed, my health plan and/or ETF will provide me with an authorization form.
5. Any children, as defined in the contract, listed on this application are not married during the year in which they turn 27 and not eligible for coverage under a group health insurance plan that is offered by their employer for which the amount of their premium contribution is not greater than the premium amount for their coverage under this program. Children may be covered through the end of the month in which they turn 27. Children may also be covered beyond age 27 if they:
 - have a disability of long standing duration, are dependent on me or the other parent for at least 50% of support and maintenance, and are incapable of self-support and are not married; or
 - are full-time students and were called to federal active duty when they were under the age of 27 years and while they were attending, on a full-time basis, an institution of higher education and are not married.
6. I understand that if my insured domestic partner and/or dependent children are not considered "tax dependents" under federal law, my income will include the fair market value of the health insurance benefits provided to my domestic partner and/or dependent children. Furthermore, I understand this may affect my taxable income and increase my tax liability.
7. I understand that it is my responsibility to notify the employer, or if I am an annuitant or continuant to notify ETF, if there is a change affecting my coverage, including but not limited to, a change in eligibility due to divorce, marriage or domestic partnership, a change in the "tax dependent" status of my domestic partner and/or dependent children, or an address change due to a residential move. Furthermore, failure to provide timely notice may result in loss of coverage, delay in payment of claims, loss of continuation rights and/or liability for claims paid in error. Upon request, I agree to provide any documentation that ETF deems necessary to substantiate my eligibility or that of my dependents.
8. I understand that if there is a qualifying event in which a qualified beneficiary (me or any dependents) ceases to be covered under this program, the beneficiary(ies) may elect to continue group coverage as permitted by state or federal law for a maximum of 36 months from the date of the qualifying event or the date of the notice to my employer, whichever is later. I also understand that if continuation coverage is elected by the affected qualified beneficiary and there is a second qualifying event (i.e, loss of eligibility for coverage due to death, divorce, marriage but not including non-payment of premium) or a change in disability status as determined by the Social Security Administration, continuation coverage, if elected subsequent to the second qualifying event, will not extend beyond the maximum of the initial 36 months of continuation coverage. I understand that notification of these events must be made to ETF in order to take advantage of the maximum 36 months.
9. I understand that if I am declining enrollment for myself or my dependents (including spouse or domestic partner) because of other health insurance coverage, I may be able to enroll myself and my dependents in this plan if I or my dependents lose eligibility for that other coverage (or if the employer stops contributing toward that other coverage). However, I must request enrollment within 30 days after my or my dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if I have a new dependent as a result of marriage, domestic partnership, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependents if I request enrollment within 30 days after the marriage or effective date of the domestic partnership, or within 60 days after the birth, adoption, or placement for adoption. To request special enrollment or obtain more information, I should contact my employer (or ETF if I am an annuitant or continuant).
10. I agree to abide by the terms of my benefit plan, as explained in any written materials I receive from ETF or my health plan, including, without limitation, the ***It's Your Choice*** booklets.