

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* (date) _____
 Divorced (date) _____ Widowed (date) _____ Domestic Partnership* (date) _____
*Spouse/Domestic Partner (DP) Name _____ SSN _____ Birth Date _____

| | |
|--|--|
| <p>ELIGIBILITY STATUS (check one) <input type="checkbox"/> Employee <input type="checkbox"/> Survivor <input type="checkbox"/> Continuant (COBRA) <input type="checkbox"/> Annuitant <input type="checkbox"/> Graduate Assistant</p> | <p>I WANT MY COVERAGE TO BE EFFECTIVE: <input type="checkbox"/> As soon as possible <input type="checkbox"/> When employer contributes premium <input type="checkbox"/> It's Your Choice (January 1)</p> |
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COVERAGE DESIRED Single Family **HEALTH PLAN SELECTED** _____

2. REASON FOR APPLICATION

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| <p>A. Check all boxes that apply. Go to Section 3.</p> <p><input type="checkbox"/> Initial Enrollment – 02 <input type="checkbox"/> Moved from Service Area – 41 Date: _____ <input type="checkbox"/> Change to Family Coverage – 43 <input type="checkbox"/> Change to Single Coverage – 44 or 45 <input type="checkbox"/> Spouse/DP to Spouse/DP Transfer - 31 Spouse's/DP's State Agency _____ <input type="checkbox"/> Transfer from One State Agency to Another – 04 Name of previous State Agency _____ <input type="checkbox"/> COBRA (or continuation) – 63 <input type="checkbox"/> It's Your Choice – 40 Current Health Plan _____ <input type="checkbox"/> Other: _____</p> | <p>B. Check all boxes that apply. Complete event date.</p> <p>Event Date: _____</p> <p><input type="checkbox"/> Cancellation – 09 <input type="checkbox"/> Name Change, former name _____ <input type="checkbox"/> Address Change (indicate in Section 1) <input type="checkbox"/> Telephone Number Change (indicate in Section 1) <input type="checkbox"/> Social Security Number Correction to _____ for (name) _____ <input type="checkbox"/> Update Other Insurance Coverage (complete Section 6)</p> |
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C. **Complete the following for deleting a dependent. List only dependents affected by this change below.**

Reason: Divorce/DP terminated Age** Dependent Married Other _____

***Dependent turned 27 or is over 18 and is eligible for health insurance through employer; grandchild of a dependent that turned 18.*

| Last Name | First | Middle | Birthdate | | | 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 ELIGIBIL- ITY PROVIDES AN OPPORTUNITY FOR CONTINUATION COVERAGE (COBRA) UP TO 36 MONTHS PROVIDED NOTICE IS GIVEN TO THE EMPLOYER WITHIN 60 DAYS OF EVENT |
|-----------|-------|--------|-----------|-----|----|---------------|---------------------------|---------------|---|---|
| | | | Mo | Day | Yr | | | | | |
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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 or adoption status; ETF affidavit required for domestic partnership.*

Dependents include spouse or domestic partner and unmarried children. 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 | Student Status | Disabled? (Y/N) | Tax Dep? (Y/N) | Select Physician or Clinic | | |
|---------------------------|-------|--------|----------|-----------|--------------|------------------------|-----------|----------------|-----------------|----------------|----------------------------|-----|----|
| Last Name | First | Middle | Previous | Birthdate | | | | | | | | | |
| | | | | Mo | | | | | | | | Day | Yr |
| Applicant | | | | | | | | | | | | | |
| Spouse/Domestic Partner | | | | | | | | | | | | | |
| Dependent Children | | | | | | | | | | | | | |
| | | | | | | | | | | | | | |
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4. ADDITIONAL INFORMATION

a. Are the dependent children listed above married? Yes No If yes, name(s) _____

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

b. Is your spouse/DP a State of Wisconsin employee (including University of Wisconsin)? Yes No

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

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. Reason _____

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.

| | | |
|---|--------------------------|---------------------|
| SIGN HERE & Return to Employer → | 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 | 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 (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 ADVANCE EMPLOYEE EMPLOYER