

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							
				Mo	Day	Yr				
Applicant										
Spouse/Domestic Partner										
Dependent Children										

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