P.O. Box 8430—Madison, WI 53708-8430

WISCONSIN STATE EMPLOYEES GROUP ENROLLMENT FORM

Reason for Submitting Application–First of the month following:

EMPLOYEE ADD: ❑ 30 DAYS ❑ 2 MONTHS ❑ TRANSFER ❑ WAIVER ❑ DEPENDENT ADD ❑ 6 MONTHS (LTE ONLY)

CUSTOMER NUMBER: ______________________________

❑ CHANGE: ______________ to ________________ Reason ________________ Date of Occurrence _________

❑ DELETE: ______________ Reason _____________ Date of Occurrence _________

❑ OTHER: ❑ BENEFICIARY CHANGE (change below) ❑ ADDRESS CHANGE ❑ OPEN ENROLLMENT

____
Group Name (Group Number) (Dept. No.)

Information about You

LAST NAME	FIRST	MIDDLE	HOME PHONE ( )

YOUR ADDRESS	NUMBER AND STREET	CITY	STATE	ZIP

DATE OF BIRTH	SEX ❑ M ❑ F	DATE OF EMPLOYMENT	SOCIAL SECURITY NUMBER	COVERAGE REQUESTED FOR: ❑ YOU ❑ SPOUSE/DOMESTIC PARTNER ❑ CHILDREN

Information about Your Family **PLEASE COMPLETE THIS SECTION FOR SPOUSE/DEPENDENT INSURANCE**

Name	Date of Birth			Gender (M/F)	Social Security Number	Relationship To Applicant	Disability Indicator (Y/N)	Taxable Dependent (Y/N)	Student Status (F/P)	Name of Educational Institution
	Mo	Day	Yr							
Spouse/Domestic Partner										
Dependent Children										

Beneficiary's Last Name	First	Middle	Relationship

Information about Other Coverage

A. I have the following group health insurance plan:
❑ State of Wisconsin Health Plan
❑ Primary Health Plan not sponsored by the State of Wisconsin
❑ Name of Primary Plan ____

B. The following are covered under Medicare:
❑ Self ❑ Part A only Date __________ ❑ Part A & B Date __________
❑ Spouse/Domestic Partner ❑ Part A only Date __________ ❑ Part A & B Date __________
❑ Dep. Child, Name ____________ ❑ Part A Only Date __________ ❑ Part A & B Date __________

C. If spouse is also employed, please complete the following:
Name of employer: ____
Name and telephone number of spouse's insurance carrier: ______________________________
Spouse's group plan is: ❑ Health ❑ Individual ❑ Family
❑ Dental ❑ Individual ❑ Family Effective Date: __________________________

I have answered the above to the best of my knowledge and belief. I understand EPIC is relying upon this information in determining my acceptance for coverage and that any misstatements or failure to provide sought for information may be used as the basis for rescission of my insurance.

______________________________ ______________________________
Signature of Applicant Date of Application

OFFICE USE						
	DATE RECEIVED BY GROUP/INITIALS	GROUP NO.	DEPARTMENT NO.	EFFECTIVE DATE	CLASS	PREMIUM

E11444-0911

WHITE COPY: EPIC YELLOW COPY: EMPLOYER PINK COPY: INSURED