GROUP HEALTH INSURANCE APPLICATION/CHANGE FORM

State of Wisconsin Employees and Annuitants
Wisconsin Public Employees and Annuitants
UW Graduate Assistants, Employees in Training, Short-Term Academic Staff, Fellows and Scholars
Wis. Stat. § 40.51

You must submit this application to your employer if you are actively employed, or to the Department of Employee Trust Funds if you are an annuitant or on continuation. Use this form when electing, declining, or canceling health insurance coverage; making changes; and adding or deleting a dependent. For complete enrollment and program information, read the *It's Your Choice* booklets. Your initial enrollment period is as follows:

a) Within 30 days of your date of hire to be effective the first of the month on or following receipt of application by the employer; or

b) **(State employees only)** Before becoming eligible for state contribution (completion of two months of state service under the Wisconsin Retirement System (WRS) for permanent/project employees; six months of state service for state limited term employees or completion of 1000 hours of service for WISCRAFT employees. This does not apply to UW unclassified faculty/academic staff.

c) **(Wisconsin Public Employers' participants only)** Within 30 days prior to becoming eligible for employer contribution.

d) **(Graduate Assistants only)** When you are notified of your appointment, immediately contact your benefits/payroll/personnel office for health insurance enrollment information and an application. If eligible, you may enroll for single or family coverage in any of the available health plans without restriction or waiting periods for pre-existing medical conditions. Your benefits/payroll/personnel office must receive your application within 30 days of the date of your first eligible appointment. Your health insurance coverage will be effective the first day of the month on or following receipt of your application by your employer.

   If this is not your first eligible appointment, you may still be eligible for the initial 30-day enrollment period if you had a 30-day employment break between appointments. If you are currently an active participant under the WRS, you are not eligible for coverage under the graduate assistant program.

If you choose to enroll within your initial enrollment period, we recommend that you submit this application to your employer immediately upon employment. If you missed your enrollment opportunity there may be other enrollment periods available to enroll without limitations or waiting periods. For complete enrollment and program information, read the *It's Your Choice* booklets.

There are no interim effective dates, except as required by Federal HIPAA law. If your application is submitted after these enrollment periods, you will be subject to waiting periods as described in the *It's Your Choice* booklets.

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.
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. 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. 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 Student Status column is required only if the dependent child(ren) is between the ages of 19 and 27:

F=Full-Time, P=Part-Time, and N=Not a Student.

Indicate "Yes" or "No" if the dependent 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 you have selected the Standard Plan, please 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 (for example, EPIC or DentalBlue).

SECTION 7 – SIGNATURE

Read the **TERMS AND CONDITIONS** on the reverse side 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. Your employer will complete Section 8 and provide a copy of the application to you. For annuitants/continuants, ETF will complete section 8 and provide a copy of the application to you.
4. 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* (*date*) _____
☐ Divorced (*date*) _____ ☐ Widowed (*date*) _____ ☐ Domestic Partnership* (*date*) _____
*Spouse/Domestic Partner (DP) 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 – 02
☐ Moved from Service Area – 41 Date:_____
☐ Change to Family Coverage – 43
☐ Change to Single Coverage – 44 or 45
☐ Spouse/DP to Spouse/DP Transfer - 31
Spouse's/DP's State Agency_____
☐ Transfer from One State Agency to Another – 04
Name of previous State Agency_____
☐ COBRA (or continuation) – 63
☐ It's Your Choice – 40 Current Health Plan _____
☐ Other:_____

B. Check all boxes that apply. Complete event date.

Event Date: _____
☐ Cancellation – 09
☐ Name Change, former name_____
☐ Address Change (indicate in Section 1)
☐ Telephone Number Change (indicate in Section 1)
☐ Social Security Number Correction to_____
for (name)_____
☐ Update Other Insurance Coverage (complete Section 6)

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 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 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.

(Continued on reverse side)

Applicant Name	Social Security Number

3. ENROLLMENT INFORMATION

Last Name First Middle Previous	Birthdate Mo	Day	Yr	Gender (M/F)	Social Security Number	Rel. Code	Student Status	Disabled? (Y/N)	Tax Dep? (Y/N)	Select Physician or Clinic
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/domestic partner 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	Name of Employer	Program Option Code	Surcharge Code
69-036-			

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 or Graduate Assistant Appointment Began (MM/DD/CCYY)
1. Did employee participate under WRS prior to being hired by you? ☐ Yes ☐ No 2. Previous service check completed? ☐ Yes ☐ No 3. Source of previous service check: ☐ Online Network for Employers(ONE) ☐ 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**

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 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; 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.
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.