Department of Employee Trust Funds

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 to: decline, add or cancel health insurance coverage; change health plans, change coverage levels, or update personal information; and add or remove dependents. For complete enrollment and program information, read the *It's Your Choice* guides. 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 limited term employees or completion of 1,000 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. 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 opportunities available. There are no interim effective dates, except as required by federal HIPAA law. If your application is submitted after these enrollment opportunities, you will not be eligible to enroll until the annual It's Your Choice Open Enrollment period. For complete enrollment and program information, read the *It's Your Choice* guides.

INSTRUCTIONS FOR COMPLETING HEALTH INSURANCE APPLICATION/CHANGE FORM

SECTION 1 – APPLICANT INFORMATION

1. *Print* your responses *clearly* and *legibly; and provide all information requested*.
2. 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's name, SSN and birth date, even if you are applying for single coverage.
3. For initial enrollment only, indicate when you want coverage to start: 1) immediately (as soon as possible); 2) when you become eligible for the employer contribution toward the health insurance premium; or 3) It's Your Choice Open Enrollment period.
4. Coverage Desired: Indicate level of coverage desired by checking either single or family.
5. Health Plan Selected: Indicate the name of the health plan that you want to provide your health insurance.

SECTION 2 – REASON FOR APPLICATION

1. Indicate the reason for submitting this application by checking the box(es) that apply under subsections A, B, C, D, E, F, G or H. If you are completing an application to change coverage level under subsection D, or to add a dependent under subsection H due to marriage, creating a domestic partnership, birth, adoption or placement for adoption, and also wish to change health plans under subsection C, a second application must be completed to change health plans.
2. Subsection A—If declining coverage check the box and go to Section 7 to date and sign your application.
3. Subsection F—When updating personal data, this can be done on the same application when selecting a reason under subsections B, C, D, E, G or H, or on a separate application.
4. If electing a Change from Family to Single Coverage or Canceling Coverage, you must also check the pre-tax/post-tax box that applies. If you have your employee premium share taken pre-tax, Internal Revenue Code Section 125 restricts mid-year changes to your coverage.

SECTION 3 – APPLICANT/DEPENDENT INFORMATION

Provide all information requested in this Section for yourself and any eligible dependents, if applicable, when selecting a reason under Adding Coverage, Subsection B; Changing Health Plan, Subsection C; and Changing Coverage Level, Subsection D.

When selecting a reason under Remove Dependents, Subsection G; or Add Dependents, Subsection H, provide all information requested in the Applicant/Dependent Information Section for all dependents who are being removed or added.

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	

03=Minor Child Parent of Minor Dependent (This relationship is a Legal Ward, Stepchild, Child, or Dependent of Domestic Partner who is under age 18 and is the parent of any of your grandchildren listed as an eligible dependent on this application. Your grandchildren cannot be covered on your contract unless the parent of the grandchild is covered and is under 18.)

Indicate "Yes" or "No" if any dependent older than age 26 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" and list the name of your grandchild's parent.

SECTION 5 – MEDICARE INFORMATION

Indicate "Yes" or "No" if you or 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 the Medicare Part A and/or Part B 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 last page.

1. When submitting an application for any reason, you are required to read the Terms and Conditions on the last page. You must also check the box that you are applying for coverage, have read and agree to the Terms and Conditions, and sign and date the application.
2. Submit the application to your payroll representative or to ETF if you are an annuitant or continuant.
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 Open Enrollment period, make a copy for your records.

To establish a domestic partnership, click on the following link and complete this form:

Affidavit of Domestic Partnership ET-2371

To enroll a domestic partner in the State of Wisconsin Group Health Insurance Program:

- Attach a copy of your ETF acknowledgement letter to this insurance application.
- Retain copies of all documents for your records.

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

Home Mailing Address—Street and No.	City	State	Zip Code

County	Country (if not USA)	Primary Telephone No.	Daytime Telephone No.
		( )	( )

MARITAL OR DOMESTIC PARTNERSHIP STATUS:

☐ Single ☐ Married *(date)* _____ ☐ Divorced *(date)* _____ ☐ Widowed *(date)* _____ mm/dd/yyyy

☐ Domestic Partnership *(date)* _____ mm/dd/yyyy

Spouse/Domestic Partner Name _____ SSN _____ Birth Date _____ mm/dd/yyyy

ELIGIBILITY STATUS (check one):

☐ Employee ☐ Graduate Assistant ☐ Survivor

☐ Continuant (COBRA) ☐ Annuitant

EMPLOYMENT STATUS (check one):

☐ Full Time ☐ Part Time

☐ Limited Term Employee ☐ Retiree ☐ N/A

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. Decline Coverage

☐ I do not wish to enroll at this time. *(Go to Section 7 to sign and date your application.)*

B. Add Coverage *(Check one box below and indicate the date of event. Update Section 3.):*

☐ New Hire
☐ Birth
☐ Adoption
☐ National Medical Support Notice
☐ Marriage or Domestic Partnership
☐ Spouse/Domestic Partner to Spouse/Domestic Partner Transfer
☐ Loss of Other Coverage/Employer Contributions
☐ LTE New Hire (State Only)
☐ Transfer from One Employer to Another Employer
Name of Previous Employer:_____
☐ It's Your Choice Open Enrollment Period
☐ Other:_____

Date of event: _____ mm/dd/yyyy

C. Change Health Plan *(Indicate current health plan, check one box below and indicate the date of the event. Update Section 3.):*

Current Health Plan: _____

☐ Move from Service Area
☐ It's Your Choice Open Enrollment period
☐ Due to Birth, Adoption, Marriage/Domestic Partnership

Date of event: _____ mm/dd/yyyy

D. Change Coverage Level

☐ Single to Family Coverage Due to *(Check one box below and indicate the date of event. Update Section 3.):*

☐ Marriage/Domestic Partnership
☐ Birth
☐ Adoption
☐ National Medical Support Notice
☐ Legal Ward, Paternity Acknowledgment
☐ It's Your Choice Open Enrollment Period
☐ Dependent Loss of Coverage
☐ Other:_____

Date of event: _____ mm/dd/yyyy

☐ Family to Single Coverage — If your employee premium share is taken pre-tax, Internal Revenue Code Section 125 restricts mid-year changes to your coverage. My employee-required premium contribution is deducted (Check one box below and update Section 3.):

☐ post-tax. Mid-year changes to your coverage level can be made at any time.
☐ pre-tax, and my employee premium contribution has increased significantly.
Date of event: _____ mm/dd/yyyy
☐ pre-tax, and my spouse and all dependents became eligible for and enrolled in other group coverage.
Date of event: _____ mm/dd/yyyy
☐ pre-tax, and my last dependent has become ineligible for coverage under this plan.
Date of event: _____ mm/dd/yyyy
☐ pre-tax, and I wish to change to single coverage during the annual It's Your Choice Open Enrollment period.

Applicant Name ,	Social Security Number

2. REASON FOR APPLICATION (Continued)

E. Cancel Coverage

I wish to *(Check one of the two following boxes.)*:

- ☐ cancel my current coverage.
- ☐ cancel my current family coverage to complete a spouse-to-spouse transfer.

My premiums are deducted: (Check one of the two following boxes):

- ☐ post-tax. Coverage may be cancelled at any time.
- ☐ pre-tax. Coverage may be cancelled only if a qualifying event occurs or during the annual It's Your Choice Enrollment period. (Check one of the following boxes if your premiums are deducted pre-tax and provide the date of event.)
  - ☐ I am terminating employment.
  - ☐ I am going on unpaid leave of absence.
  - ☐ I am going to less than half-time employment.
  - ☐ My employee premium contribution has increased significantly.
  - ☐ I (and all my dependents, if applicable) became eligible for and enrolled in other group coverage.
  - ☐ Annual It's Your Choice Open Enrollment period

Date of event: _____ mm/dd/yyyy

F. Update Personal Data *(Check all boxes below that apply.)*:

- ☐ Name Change:
  Indicate former name_____
- ☐ Address Change (Indicate updated address in Section 1.)
- ☐ Telephone Number Change (Indicate updated telephone number in Section 1.) mm/dd/yyyy
- ☐ Date of Birth Correction to (Date) _____for (Name)_____
- ☐ Social Security Number Correction to _____ for (Name)_____
- ☐ Marital Status and/or Marital Status Date Correction (Indicate updated marital status information in Section 1.)
- ☐ Medicare Information Update, complete Section 5.
- ☐ Other Insurance Update, complete Section 6.

If you are unable to provide a Social Security Number for a non-citizen spouse or non-citizen eligible dependent, click on the following link and complete this form:

Affidavit for Insurance Purposes UWS 93

Submit the Affidavit with this application to your payroll & benefits office.

G. Remove Dependents *(Check one box below and indicate the date of event. Update Section 3 with dependents being removed.)*:

- ☐ Divorce
- ☐ Domestic Partnership Terminated
- ☐ Death of Dependent
- ☐ Dependent Marriage
- ☐ Removing Adult Dependent During Annual It's Your Choice Open Enrollment period
- ☐ Disabled Dependent: Disability Ends
- ☐ Disabled Dependent: Support and Maintenance Less than 50%
- ☐ Legal Guardianship Ends
- ☐ Grandchild's Parent Turns 18
- ☐ Other:_____

Date of event: _____ mm/dd/yyyy

Note: The deletion of a dependent due to loss of eligibility provides an opportunity for continuation coverage (COBRA) provided notice is given to the employer within 60 days of the event.

H. Add Dependents *(Check one box below and indicate date of event. Update Section 3 with dependents being added.)*:

- ☐ Marriage
- ☐ Domestic Partnership*
- ☐ Birth
- ☐ Adoption*
- ☐ National Medical Support Notice*
- ☐ Legal Guardianship*
- ☐ Paternity Acknowledgment*
- ☐ Adult Dependents, Annual It's Your Choice Period
- ☐ Dependent Loss of Other Group Coverage*
- ☐ Eligible Dependent Not Included on Initial Enrollment (Domestic partner or adult children cannot be Enrolled for this reason.)
- ☐ Disabled, Over Age 27*
- ☐ Other:_____

Date of event: _____ mm/dd/yyyy

*The addition of dependents due to these reasons requires supporting documentation. Check the It's Your Choice Reference Guide for specific documentation requirements.

3. APPLICANT/DEPENDENT INFORMATION — Complete all requested information.

Last Name First Middle Previous	Birth Date Mo Day Yr mm/dd/yyyy	Gender (M/F)	Social Security Number	Rel. Code	Disabled? (Y/N)	Tax Dep? (Y/N)	Select Physician or Clinic
Applicant			☐ Applied For				
Spouse/Domestic Partner			☐ Applied For				
Dependent Children			☐ Applied For				
			☐ Applied For				
			☐ Applied For				
			☐ Applied For				
			☐ Applied For				

Applicant Name ,	Social Security Number

4. ADDITIONAL INFORMATION

a. Are any of the dependents listed under Applicant/Dependent Information 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 mm/dd/yyyy Part B mm/dd/yyyy 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 or annuitant (including University of Wisconsin)? ☐ Yes ☐ No

7. SIGNATURE (Read the **TERMS AND CONDITIONS** on the last page, **check the box below** and sign the application.)

☐ 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.

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 ➡	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

1. Did employee participate under WRS prior to being hired by you? ☐ Yes ☐ No
2. Previous service check completed? ☐ Yes ☐ No

Source of previous service check: ☐ Online Network for Employers (ONE) ☐ ETF

Date Application Received by Employer (MM/DD/CCYY)			
Date WRS Eligible Employment Began or Graduate Assistant Appointment Began (MM/DD/CCYY)			
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. Children may be covered through the end of the month in which they turn 26 if they are not enrolled in an employer-sponsored group health insurance plan. Children may also be covered beyond age 26 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 18, 29, or 36 months, depending on the type of qualifying event, 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 months of continuation coverage. I understand that timely notification of these qualifying events must be made to ETF.
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*** guides.