

Large and Small Employer

Employee Health Insurance Application

FOR OFFICE USE ONLY	
Group number	_____
Effective date	____ / ____ / ____

A signature within Section F is required to make the application valid.
 If you need additional space, use a separate sheet of paper and attach it to this application (sign and date the additional sheet).

A. Employer information

Employer legal name _____

B. Employee information

Fill out the entire application and include information for spouse and/or dependents seeking coverage.

First name, middle initial and last name				Former last name (if applicable)		Marital status:	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Social Security number		Date of birth (m/d/y)		<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Domestic partner	
Height		Weight		Physical address (PO box not accepted)		City State ZIP County	
Mailing address <input type="checkbox"/> Same as physical address				City State ZIP County			
Home phone number (area code)		Work phone number (area code)		Cell phone number (area code)			
Email address				Primary Care Provider/Facility			

Work status and qualifying election:

Actively working: Hire/Rehire date (m/d/y) ____ / ____ / ____ OR Recall date (m/d/y) ____ / ____ / ____

Retired: Date (m/d/y) ____ / ____ / ____

If you are enrolling due to a loss of coverage, submit proof of loss with your application.

COBRA or state continuation: Start date (m/d/y) ____ / ____ / ____ End date (m/d/y) ____ / ____ / ____

Special enrollment reason _____ Date of event (m/d/y) ____ / ____ / ____

Race or ethnicity: <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> Specify _____			What primary language is spoken in your home: <input type="checkbox"/> English <input type="checkbox"/> Specify _____		
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Coverage desired:

Single Employee + spouse Employee + child(ren) Family

WAIVING COVERAGE (skip to section G. Health Coverage Waiver)
 If married and only selecting coverage for yourself, complete section G for your spouse/dependent.

C. Dependent information *List everyone enrolling in coverage (spouse, dependents)*

Name (First, MI, Last)	Birth date (m/d/y)	Sex	Social Security Number	Relationship	Primary care practitioner name and facility	Age 14 & over	
						Height	Weight
	__/__/__	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic partner*			
	__/__/__	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Child/Stepchild <input type="checkbox"/> _____			
	__/__/__	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Child/Stepchild <input type="checkbox"/> _____			
	__/__/__	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Child/Stepchild <input type="checkbox"/> _____			
	__/__/__	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> Child/Stepchild <input type="checkbox"/> _____			

* If allowed by your plan

Do any of the above family members live at a different address: Yes No

If yes, indicate name and address _____

D. Information regarding other health coverage and Medicare

1. If you, your spouse or your dependent child(ren) listed in this application have current coverage that will continue after your Security Health Plan coverage starts, complete the following table.

Subscriber		DOB (m/d/y)
Insurance company	Group number	Policy number
Family members covered		Type of coverage:
		<input type="checkbox"/> Employer group health coverage
		<input type="checkbox"/> Drug coverage only
		<input type="checkbox"/> Individual health coverage

2. Are you or any of your family members eligible for Medicare: Yes No

If yes, complete the following or attach a copy of your Medicare card.

Name of person covered by Medicare _____ Medicare card number _____

Is Medicare eligibility due to: Over age 65 End-stage renal disease (ESRD) Total disability

Effective dates: Part A _____ Part B _____ Part C (Medicare Advantage) _____ Part D _____

E. Health information

Please ensure that you provided complete and thorough health data below. As an employee of a group that is new to Security Health Plan, this information is important in understanding potential health risks and identifying care management and wellness needs for employees.

1. Does anyone named in this application take any prescribed medications: Yes No

If yes, complete the following table:

Person's Name	Drug Name	Person's Name	Drug Name

2. Has anyone named in this application used tobacco or smokeless tobacco during the past 6 months: Yes No

If yes, name of each person (we reserve the right to verify this information):

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3. Has anyone named in this application ever been diagnosed with or treated for diabetes: Yes No

If yes, person's name _____ Type 1 Type 2

Date first diagnosed (m/d/y) ____ / ____ / ____ Date last treated (m/d/y) ____ / ____ / ____

4. Are you or any dependent now pregnant or an expectant parent: Yes No

If yes, person's name _____ Relationship _____ Due date (m/d/y) ____ / ____ / ____

5. Has anyone named in this application ever been diagnosed with or treated for cancer: Yes No

If yes, person's name _____ Location or type of cancer _____

Describe treatment _____

Date first diagnosed (m/d/y) ____ / ____ / ____ Date last treated (m/d/y) ____ / ____ / ____ No recurrence

Date of any recurrence (m/d/y) ____ / ____ / ____ Describe _____

6. Has anyone named in this application ever been diagnosed with or treated for heart disease: Yes No

If yes, person's name _____ Describe disease _____

Describe treatment _____

Date first diagnosed (m/d/y) ____ / ____ / ____ Date last treated (m/d/y) ____ / ____ / ____

7. Within the past 5 years, has anyone named in this application (to be covered by this insurance) had:
- a. Any other injury, illness or treatment for any condition not already listed: Yes No
 If yes, person's name _____ describe (include date) _____
- b. Been hospitalized or been scheduled for hospitalization: Yes No
 If yes, person's name _____ describe (include date) _____
- c. Had any surgery or has surgery scheduled: Yes No
 If yes, person's name _____ describe (include date) _____
- d. Had a test or has a test scheduled: Yes No
 If yes, person's name _____ describe (include date) _____
- e. Been recommended to have a test or surgery which was not performed for any reason not already mentioned in this application (we are not seeking the results of HIV antibody test.): Yes No
 If yes, person's name _____ describe (include date) _____
8. Has anyone named in this application had a history of, is being considered for, is on a list for, or is scheduled for a transplant: Yes No
 If yes, describe (include date) _____

F. Terms and conditions

- All statements and answers in this application are representations made by the applicant on his/her own behalf and for the other persons named in this application to induce the issuance of the contract(s) applied for.
- Subject to acceptance of this application by Security Health Plan of Wisconsin, Inc., it is understood and agreed that each participant consents to furnish Security Health Plan of Wisconsin, Inc., with all such medical and surgical reports, records and other information as requested to process claims. This might include signing a form for the release of information from hospitals, doctors and other health care providers to Security Health Plan of Wisconsin, Inc.
- Subject to the acceptance of this application by Security Health Plan of Wisconsin, Inc., the applicant authorizes the named group as his/her remitting agent to deduct from his/her wages or salary an amount equal to a) the existing subscription fees or b) the difference between the existing subscription fees and that contribution made by his/her employer.
- Any misrepresentation contained in this application and relied upon by the insurer may be used to reduce or deny a claim or void the contract within the contestable period if such misrepresentation materially affects the acceptance of risk. I also understand that if I decline any coverage, future changes in coverage are NOT automatic and may be subject to the insurer's approval. I further understand and acknowledge that any person with intent to defraud or knowledge of facilitating a fraud against an insurer, submits an application or files a claim using a false and/or deceptive statement is committing a crime.
- This form is an application for coverage only. Regardless of any advance payment of premiums, the policy applied for will become effective only upon the acceptance of this application by Security Health Plan of Wisconsin, Inc., to be evidenced by the issuance of an identification card and booklet/certificate.

I agree that the above answers are true and complete to the best of my knowledge and are made to induce the issuance of and as part of the policy I am applying for. I apply for enrollment subject to the terms and conditions above.

Applicant's signature (required) _____

_____/_____/_____
Date (m/d/y)

If you are waiving coverage for ANYONE, make sure you sign page 5 of the application.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Complete this section if someone assisted you in the completion of this application.

The following person assisted me in completing the application _____

Explain your relationship with the applicant _____

G. Health coverage waiver

I understand that if I decline coverage at this time for my spouse/domestic partner, my dependent children or myself and apply for coverage later, I/they may need to wait for coverage until an annual enrollment date.

1. I understand that I am eligible to apply for group health insurance through my employer. I do not want, and hereby waive, group health insurance for the following individuals: (check [✓] all boxes that apply)

Myself Spouse Dependent child(ren) _____

2. I am waiving group health insurance because: (check [✓] all boxes that apply)

I (and/or any dependents) will be covered by another health benefit plan.

Name of insurance company _____

The annualized premium contribution to be paid by me on behalf of myself or my dependent spouse and child(ren) would exceed 10% of my annualized gross earnings from this employer (applicable for small employers only).

Other reason _____

Waiver:

I certify that I have been given the opportunity to apply for group health insurance and decline to enroll as indicated above, on behalf of myself, my spouse and/or my dependent child(ren). I understand that by signing this waiver, I, my spouse and/or my dependent child(ren) forfeit the right to coverage. I was not pressured, forced or unfairly induced by my employer, the agent or the insurer(s) into waiving or declining the group health insurance. If in the future I apply for coverage, I, my spouse or any of my dependent child(ren) 19 years and older may be treated as a late enrollee and subject to postponement.

I understand that if I am declining enrollment for myself, my spouse or my dependent child(ren) because of other health insurance, I may in the future be able to enroll myself, my spouse or my dependent child(ren) in this plan, provided that I request enrollment within 31 days after my other health coverage ends. In addition, if I gain a dependent spouse or child(ren) as a result of marriage, birth, adoption or placement for adoption, I understand that I may be able to enroll myself, my spouse and/or my dependent child(ren), provided that I request enrollment within 31 days after the marriage, birth, adoption or placement for adoption. I understand that I can obtain enrollment information from my employer or group health insurance carrier.

Signature _____ Date (m/d/y) _____ / _____ / _____

If you are electing coverage for yourself, please make sure you sign page 4 of the application.

H. Nondiscrimination notice

Security Health Plan of Wisconsin, Inc., complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status.

Limited English Proficiency Language Services

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-800-472-2363 (TTY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-472-2363 (TTY: 711).

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-472-2363 (TTY: 711).