EMPLOYEE'S GROUP ENROLLMENT APPLICATION

Instructions: Please complete all applicable areas of this application. Please print using **black** ink. WPS/Delta Dental of Wisconsin/ Wisconsin Physicians Services Insurance Corporation/WPS Health Plan, Inc. d/b/a Arise Health Plan ("Insurer or Third Party Administrator (TPA") does NOT guarantee approval of this application for any person, or issuance of a policy. When complete, please mail this application to the appropriate company shown on Page 6.

Please choose which company you are applying for coverage through: ❑ **WPS** ❑ **Arise Health Plan**

Section 1 – Employer Information *(to be filled out by employer)*

Employer Name	Employer Telephone Number
Group Number	Subgroup

Section 2 – Employee Information

First Name	Middle Name	Last Name	Suffix
Home Address	Apartment of Suite Number		Social Security Number
City	State	ZIP Code	County
Home Phone Number	Work Phone Number		Date of Birth

Gender	Marital Status	Employee Date of Hire	Job Title	Hours Worked Per Week	Height/Weight
❑ Male ❑ Female	❑ Single ❑ Married ❑ Divorced ❑ Widowed				

WPS and Arise are committed to support an Eco-friendly environment. The communications you received from us will be available on our Member portals.	Work Email Address	Home Email Address

Section 3 – Reason for Application

❑ New Employee ❑ New Group Enrollee due to Open Enrollment

❑ Special Enrollment due to:

- ❑ Involuntary loss of Minimum Essential Coverage for any reason other than fraud, intentional misrepresentation of a material fact or failure to pay premium
- ❑ Marriage ❑ Birth ❑ Adoption or placement for adoption or appointment of legal guardianship
- ❑ Other: _____

Please provide the date of the qualifying event: _____

❑ COBRA – reason: _____ Start Date: _____ Termination Date: _____

❑ Add Dependent(s)

❑ Changing_____to _____ Effective Date: _____

❑ Change Benefit Plan – Current_____Change to: _____

❑ Change Network Option – Current_____Change to: _____

❑ Change PCP – Please indicate which covered member is changing PCPs and the new PCP information:

❑ Deleting Coverage (Explain): _____

❑ Other – Please indicate: _____

Section 4 – Type of Health Coverage Requested

Type of Coverage	Applying For	Waiving/Declining Coverage For
Group Medical Coverage ❑ WPS PPO Plan ❑ WPS HDHP Plan ❑ Arise POS Plan ❑ Arise HMO Plan ❑ Arise POS HDHP ❑ Arise HMO HDHP	❑ Myself ❑ My Spouse ❑ My Dependents	❑ Myself ❑ My Spouse ❑ My Dependents
Group Dental Coverage ❑ Dental PPO (Underwritten by Delta Dental)	❑ Myself ❑ My Spouse ❑ My Dependents	❑ Myself ❑ My Spouse ❑ My Dependents

Please list the name of the Preferred Provider Network you choose (if applicable):_____For the Dental HMO Plan, please list the provider you have chosen:_____

Section 5 – Health Coverage Waiver

If anyone named on this application is waiving or declining any coverage, please provider his/her name and check the reason he/she is waiving/declining:

Name(s) of person(s) waiving/declining:_____

❑ I am covered or will be covered under another plan that is not sponsored by my employer.

❑ My dependents are covered or will be covered under another plan that is not sponsored by my employer.

❑ Other:_____

Waiver: I certify that I have been given the opportunity to apply for group coverage and decline to enroll as indicated on behalf of me and/or my dependents. I understand that by signing this waiver, I and/or my dependents forfeit the right to coverage.

I understand that if I am declining enrollment for myself or my dependents (including my spouse) because of other health coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that I request enrollment within 31 days after my coverage ends. In addition, If I have a new dependent as a result of marriage, birth, adoption or placement for adoption, I understand that I may be able to enroll myself and my dependents provided that I request enrollment within 31 days after the marriage, birth or adoption. I further understand that, other than these qualifying events, if this form is submitted after the enrollment period, I cannot enroll until the next annual enrollment period, if applicable.

_____ _____ _____

SIGNATURE (required if waiving coverage) **PRINT NAME** **DATE**

Section 6 – Notice of Special Enrollment Rights for Health Coverage

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose coverage (or if the employer stopped contributing towards you or your dependent's other coverage.)

Loss of coverage events include, but are not limited to: (a) the person no longer lives, resides or works within his or her HMO service area, the HMO does not provide coverage for that reason and there is no other coverage under the plan for the individual; (b) a dependent loses dependent status because he or she attains a particular age; (c) the plan no longer offers any benefits to a class of similarly-situated individuals (such as if the plan terminates coverage for all part-time workers); and (d) a benefit package option terminates or the issuer stops operating in the group market.

However, you must request enrollment within 31 days after you or your dependent's other coverage ends (or after the employer stops contributing towards the other coverage.)

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and other dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

This notice is for informational purposes only and is informing you of your special enrollment rights.

Section 7 – Applicant Enrollment Information

A. Please complete the following for all family members, beginning with you the employee, who are applying for coverage. If additional space is needed, please attach a separate sheet with completed information.

	Sex	Social Security Number	Relationship to Applicant	Height	Weight	Date of Birth
Spouse Name (First, MI, Last)	❑ Male ❑ Female					
Dependent Name (First, MI, Last)	❑ Male ❑ Female					
Dependent Name (First, MI, Last)	❑ Male ❑ Female					
Dependent Name (First, MI, Last)	❑ Male ❑ Female					
Dependent Name (First, MI, Last)	❑ Male ❑ Female					

Section 8 – Medical Information

A. **Total Disability.** Is anyone named in this application now disabled or unable to perform normal work – or age-related activities? ❑ Yes ❑ No

If yes, please identify names, conditions, dates of disability, and name and address of attending physician:_____

_____

B. Within the past six months, has anyone named in this application who is age 18 or over used tobacco regularly (four or more times per week on average)? ❑ Yes ❑No

If yes, please list which applicants: _____

C. **Health Questionnaire. DO NOT COMPLETE THIS SECTION IF YOU ARE ENROLLING AS AN EMPLOYEE IN A SMALL GROUP PLAN (FEWER THAN 50 TOTAL EMPLOYEES) OR AS A NEW HIRE OR LATE ENROLLEE INTO AN EXISTING PLAN.** If you are enrolling for coverage(s) as part of a new group, please fill out the appropriate subsection below according to the number of employees *enrolled* in the group plan. Please note: you are required to forward to the Insurer or TPA any changes and/or dependents in your or any family member's health history that occur prior to your receipt of our written underwriting decisions on this application.

1. Groups 250+ Enrolled Employees

a. Is anyone named on this application being considered for, on a list for, or scheduled for a transplant? ❑ Yes ❑ No

2. Groups with 26 to 249 Enrolled Employees

a. Within the last 24 months, has anyone named in this application consulted, received treatment, had medication prescribed by a doctor, psychiatrist, psychologist, or other practitioner or been diagnosed for: (a) cancer, (b) stroke, (c) diabetes, (d) heart of vascular disease, (e) multiple sclerosis, (f) muscular or systemic disease (such as arthritis, lupus). (g) transplant, (h) liver, kidney, lung or intestinal disorder (except genetic testing results), (i) blood disorder, or (i) Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? (AIDS tests received at anonymous counseling and testing sites or through home test kits need not be revealed – *We are not seeking the results of HIV antibody Test*) ❑ Yes ❑ No

b. Are you or any dependent (even if not listed on application) pregnant or been advised in the last 12 months that hospitalization, surgery or treatment is needed or pending? (If yes, expected due date is_____) ❑ Yes ❑ No

c. Are you or any dependent named in this application currently taking any prescribed medications? ❑ Yes ❑ No

3. Groups with 2 to 25 Enrolled Employees

a. Are you or any other dependent (even if not listed on application currently pregnant? ❑ Yes ❑ No

(If yes, expected due date is:_____)

Section 8 – Medical Information Cont.

b. (1) Is anyone named in this application currently taking any medications recommended or prescribed by a physician or other health care practitioner? ❑ Yes ❑ No

(2) Has anyone named in this application had medication recommended or prescribed by a physician or other health care practitioner within the past 12 months? ❑ Yes ❑ No

c. Has anyone named in this application had a professional diagnosis of Acquire Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? AIDS tests received at anonymous counseling and testing sites or through home test kits need not be revealed. *We are not seeking the results of HIV Antibody Test.* ❑ Yes ❑ No

d. Within the last five years, has anyone named in this application been hospitalized or scheduled for hospitalization; had surgery or surgery scheduled; had a test or test scheduled; or been recommended to have a test or surgery which was not performed for any reason not already mentioned? ❑ Yes ❑ No

e. Within the last five years, has anyone named in this application been counseled, consulted, or treated for any of the following conditions: (1) heart disease or disorder; (2) stroke; (3) circulatory disorder; (4) high blood pressure; (5) diabetes; (6) connective tissue disorder; (7) allergies; (8) asthma; (9) emphysema; (10) sinus; (11) nasal or lung disease or disorder; (12) ulcers; (13) stomach or intestinal disorder; (14) thyroid disorder; (15) adrenal disorder; (16) enlargement of the lymph-nodes; (17) menstrual or gynecological disorder; (18) infertility; (19) sexual dysfunction; (20) arthritis; (21) back, joint or muscle disorder; (22) ear, skin or eye disorder; (23) cancer; (24) tumor; (25) abnormal growth; (26) nervous system disorder (including attention deficit and psychological disorders and multiple sclerosis); (27) headaches; (28) seizures; (29) epilepsy; (30) hepatitis; (31) liver disorder; (32) kidney, bladder or prostate disorder; (32) hernia; (33) rectal disorder; (34) anemia; (35) blood disorder; (36) the use of alcohol, chemicals, or drugs (been advised to cease or decrease use of); or (37) transplant. ❑ Yes ❑ No

If yes, please indicate which conditions using the corresponding numbers from above: _____

_____

4. In the spaces below, please list medications and provide full details to questions for which you answered "yes" above. If you need additional space, please attach a separate sheet of paper.

Question No.	Family Member	Date of Treatment	Identify the medication, condition, its duration, treatment and degree of recovery	Name/Address of Attending Physician

Section 9 – Information Regarding Primary Care Physicians – For Arise Health Plan Only

Please select a Primary Care Physician (PCP) for yourself, your spouse, and each dependent who is applying for coverage. If additional space is needed, please attach a separate sheet with completed information.

Last Name	First Name	MI	Primary Care Physician

Section 10 – Information Regarding Other Health Coverage and Medicare

Does any person applying for coverage currently have other individual or group health coverage? ❑ Yes ❑ No

If yes, please provide coverage information below. If additional space is needed, please attach a separate sheet with completed information.

Policyholder Information	Name, Address, & Phone Number of Insurance Company/Plan Type	Policy Number	Type of Coverage	Effective and Termination Dates of Coverage
Name: _____ ❑ Employee ❑ Spouse Date of Birth: _			❑ Single ❑ Family ❑ COBRA	
Name: _____ ❑ Employee ❑ Spouse Date of Birth: _			❑ Single ❑ Family ❑ COBRA	

Are you or any of your family members eligible for Medicare? ❑ Yes ❑ No

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

Name of person covered by Medicare: _____ Medicare Claim 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:_____

Section 11 – Terms and Conditions

I hereby enroll for coverage under the insurance coverage(s) for which I am presently eligible, or for which I may become eligible under my employer's group contract(s). I understand and agree that the information obtained by using this Application will be used by the insurer(s) or TPA to determine eligibility for benefits under my employer's group contract. I, on behalf of myself, my spouse and my dependent child(ren), if any, named herein, agree to cooperate in providing the insurer(s) or TPA with information needed to process this Application. This might include signing a form for the release by hospitals, doctors, and other health care providers of pertinent heath care records to the Medical Information Bureau, the insurer(s) or TPA or their legal representatives.

I acknowledge that I have read and completed the entire Application. If I received assistance in reading or completing this Application, I have identified in the space provided below the person(s) who provided me with such assistance. I declare and agree that the answers are, to the best of my knowledge and belief, complete and true and, together with any supplements or addendums thereto, shall be the basis for any plan document issued by the insurer or TPA. I understand and agree that neither the employer nor the agent has the authority to waive a complete answer to any question, pass on insurability, alter any contract, or waive any of the insurer's or TPA other rights or requirements. I additionally agree that the insurer(s) or TPA is not liable for any statement, representation, or other information provided to me, my spouse or my dependent child(ren) that is not expressly contained in a written document provided by the insurer or TPA and signed by an authorized officer of the insurer or TPA. I agree that no insurance will be effective until the date specified by the company on the certificate of coverage or certificate of insurance after this application has been accepted. I understand that any misrepresentation contained herein and relied upon by the insurer or TPA 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 or TPA's approval.

I understand and acknowledge that any person who, with intent to defraud or knowledge that the person is facilitating a fraud against an insurer or TPA, submits an application or files a claim containing a false deceptive statement is committing a fraudulent act that is a crime. I further understand and acknowledge that in some states, any person who, for the purpose of intentionally misleading an insurer or TPA or other person, conceals significant information from an application or claim is committing a fraudulent act.

I understand that the Insurer or TPA fully complies with the regulations and orders regarding doing business with foreign countries or foreign nationals listed on the Office of Foreign Assets Control's Specially Designated Nationals and Blocked Persons (SDN) list. Therefore, the Insurer or TPA may rescind and void any coverage if it determines that the employer, a covered employee, or a covered employee's spouse or named dependent, are either listed on the SDN list or associated with an entity listed on the SDN list. If any payroll deductions are required for this coverage, I authorize such deductions from my earnings. I reserve the right to revoke this deduction authorization at any time upon written notice to the employer. An Application should not be submitted more than 45 days prior to the effective date. This document will become a part of the insurance contract when coverage is approved and issued.

I understand that I may request a copy of this Application and the Authorization to Use and Disclose Protected Health Information that are part of this Application. I agree that a photographic copy shall be as valid as the original. A legible facsimile signature shall have the same force and effectiveness as the original.

Signature of Employee: _____ **Date Signed:** _____

Signature of Spouse: _____ **Date Signed:** _____

Complete this section if someone assisted you in the completion of this Application.
The following person assisted me in completing the Application: _____
Please explain your relationship with the Applicant: _____

Section 12 – Authorization

Authorization to release medical records: I hereby authorize any licensed physician, medical practitioner, health care provider, hospital, clinic, or other medical or medically related facility, insurance or reinsuring company, ("MIB, Inc."), Pharmacy Benefit Manager, consumer reporting agency, or other organization, institution, or person that has any record or knowledge of me or my minor children to give to the Insurer or its legal representative, reinsurers, authorized agents or designees, any and all information (including information that constitutes protected health information as defined in the privacy regulation promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996, as amended "HIPAA Privacy Regulation", but excluding psychotherapy notes, if any) in any form, including, but not limited to, in original, electronic, or photographic copies, about me or my minor children to be covered concerning diagnosis, treatment and prognosis for any physical or mental condition, history or character, general reputation, personal traits, and mode of living, including, but not limited to, all medical and health care records. The information authorized for release shall not include whether the individual has obtained a test for the presence of HIV, antigen or nonantigenic products of HIV or an antibody to HIV or the results of such a test, if obtained by the individual.

I understand the information obtained by this authorization will be used by the Insurer to determine eligibility for coverage under this policy and that my failure to authorize the release of said information might result in a refusal to issue or provide coverage. I agree that the Insurer or TPA may release said information to the Insurer or TPA's reinsuring companies, representative(s) or other person(s) performing business or legal services in connection with this application or as may be permitted or required by law, or as I may further authorize from time to time.

I understand that I may revoke this authorization by providing advance written notice of termination to the Insurer or TPA at its home office, and that any information released in reliance upon this authorization and prior to such revocation cannot be retrieved. In such case, the Insurer or TPA, its directors, officers, employees and agents shall not be held responsible or liable for such release. I understand this authorization will remain valid for 30 months from the date I execute this authorization unless revoked by me in writing prior to the end of that 30-month period.

I understand that I am entitled to receive a copy of this completed, signed authorization, and that a photographic copy shall be as valid as the original. I understand that once information is disclosed pursuant to this authorization, it may no longer be protected by the HIPAA Privacy Regulation and could be re-disclosed by the person or entity that receives it.

EMPLOYEE SIGNATURE	**PRINT NAME**	**DATE**

For contact information, please see below.

Mail to:
Wisconsin Physicians Services Insurance Corporation
P.O. Box 8190
Madison, WI 53707

Call:
1-800-236-1448

Visit:
www.wpsic.com

Mail to:
WPS Health Plan Inc. d/b/a Arise Health Plan
P.O. Box 11625
Green Bay, WI 54307

Call:
1-888-711-1444

Visit:
www.WeCareForWisconsin.com