

**SMALL EMPLOYER UNIFORM EMPLOYEE
APPLICATION FOR GROUP HEALTH
INSURANCE**



Employee Name _____

State of Wisconsin
Office of the Commissioner of Insurance
P.O. Box 7873
Madison, WI 53707-7873
(608) 266-3585
Web Address: oci.wi.gov

Ref: Section Ins 8.49, Wis. Adm. Code, and
Sections 601.41 (8), 635.10, Wis. Stat.

This form is designed for an employer's initial application for coverage. Please contact your agent or the insurer to determine if this form should be used in other situations once the group is enrolled with the insurer.

EMPLOYER INFORMATION – To be filled out by Employer

Employer Name _____ Group Number _____ Division Number _____
Employee Class _____
Total number of permanent employees who have a normal work week of 30 or more hours _____
Names of Insurers to whom information may be released:
Insurer: _____ Insurer: _____
Insurer: _____ Insurer: _____

I. EMPLOYEE INFORMATION

Employee Instructions: Please print using black or blue ink. Please fill out the entire application for each person for whom coverage is being sought.

Employee's First Name, Middle Initial and Last Name: _____
Social Security No.: _____ Birth Date: _____ Sex: _____ Height and Weight: _____
Street or Post Office Address: _____
City: _____ County: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Email: _____ [] Home [] Work

1. For your current employer: What was your first day of employment? ___/___/___
How many hours, on average, do you work each week? _____

2. Are You:

- a) Single Married Legally Separated Divorced Widow or Widower
If you are married, legally separated, divorced or widowed, please indicate the date that the event occurred: _____
If you are married, please indicate the county and state, or country in which you were married: _____
If you are married, please indicate your former or maiden name: _____
- b) A Retiree? Yes No
- c) On COBRA or State Continuation? Yes No
If "Yes," provide start date and reason: _____

II. TYPE OF HEALTH COVERAGE

Please select the type of health insurance coverage for which you are applying:

Employee Only Employee and Spouse Employee and Dependent Child(ren) Employee, Spouse and Dependent Child(ren)

III. DEPENDENT INFORMATION

a) List all dependents, spouse and child(ren) applying for insurance. If you need additional space, please use a separate sheet of paper and attach it to this application (please sign and date the additional sheet).

Name (First; M.I.; Last)	Sex	Social Security Number	Relationship	Birth Date (Mo/Day/Yr)	Height Weight
			Spouse		
			<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Grandchild <input type="checkbox"/> Other		
			<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Grandchild <input type="checkbox"/> Other		

- b) Does the dependent child(ren) named within this application live with you at the address shown above? Yes No
 If "No," please list the dependent child(ren)'s name and address(es):

- c) If there is a stipulation in a legal decree or court order stating who is responsible for providing health insurance of the named dependent child(ren), please indicate name of the person who has primary custody of the dependent child(ren) and the name of the responsible person for health insurance:

IV. MEDICAL INFORMATION

Please answer the following questions to the best of your knowledge. On the next page, please provide the complete details if you answer "Yes" to any of the questions below. The date that this application is signed is the date that you should use when answering questions that request you to provide prior history for various periods of time. The health insurance company does not use or collect genetic information for any underwriting purpose. Genetic information includes information related to genetic tests, genetic counseling, and any family history of a disease or disorder. Any such information should not be included on an application or communicated to the insurance company in any manner. Any genetic information that may be obtained will not be used for underwriting of health coverage. **You are required to promptly notify your employer so that you may provide updated information to the small employer insurer(s) of any changes or developments in your, your spouse's or your dependent child(ren)'s health history that occur prior to your employer's notifying you that there has been an insurer's underwriting decision regarding this application.**

- A. Are you, your spouse or any dependent child(ren) (even if not listed on the application) currently pregnant or an expectant parent? (If "Yes," due date is _____) Yes No
- B. Has anyone named in this application been treated or diagnosed by a medical professional as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? Yes No
- C. Has anyone named in this application used tobacco or smokeless tobacco during the past 12 months? Yes No
 If "Yes," provide information as requested regarding the product, duration and frequency of use in section H below.
- D. In the past 5 years has anyone named in this application been evaluated or treated for alcoholism or chemical dependency; or joined any organization for alcoholism or chemical dependency; or used illegal drugs or been advised by a health care professional to reduce the use of alcohol or illegal drugs? Yes No
- E. Is anyone named in this application now disabled, mentally incompetent or unable to perform normal work or age-related activities? Yes No
 If "Yes," please identify name(s), health condition(s), date(s) of disability and name(s) and address(es) of the attending physician(s):

- F. Within the past 10 years, has anyone named in this application been counseled, consulted or treated for any of the following (please check all conditions that apply):

1. CIRCULATORY SYSTEM

- a) heart disease or disorder Yes No
- b) stroke Yes No
- c) circulatory disorder Yes No
- d) chest pain Yes No
- e) high or low blood pressure Yes No
- f) elevated cholesterol and/or triglyceride levels Yes No
- g) anemia or blood disorder Yes No

2. DIGESTIVE SYSTEM

- a) ulcers Yes No
- b) stomach disorder Yes No
- c) liver/pancreas disorder Yes No
- d) gallbladder disorder Yes No
- e) intestinal disorder (e.g., colitis, Crohn's disease) Yes No
- f) hernia Yes No
- g) rectal disorder Yes No

3. GENITOURINARY SYSTEM

- a) menstrual disorder Yes No
- b) genital disorder Yes No
- c) sexual dysfunction Yes No
- d) pregnancy complications (e.g., premature birth, miscarriage, c-section) Yes No
- e) infertility Yes No
- f) urinary tract/kidney/bladder disorder Yes No
- g) prostate disorder Yes No

4. ENDOCRINE SYSTEM

- a) diabetes Yes No
- b) thyroid disorder Yes No
- c) adrenal disorder Yes No
- d) enlargement of the lymph-nodes Yes No
- e) connective tissue disorder Yes No

5. EAR OR EYE

- a) eye disorder Yes No
- b) ear disorder Yes No

6. RESPIRATORY SYSTEM

- a) allergy(ies) Yes No
- b) asthma Yes No
- c) emphysema Yes No
- d) sinus or nasal disorder Yes No
- e) lung disease or disorder Yes No
- f) shortness of breath Yes No

7. NERVOUS SYSTEM

- a) epilepsy or other seizures Yes No
- b) headaches Yes No
- c) multiple sclerosis Yes No

8. MUSCULAR or SKELETAL

- a) arthritis Yes No
- b) fibromyalgia Yes No
- c) back disorder Yes No
- d) joint disorder Yes No
- e) musculoskeletal disorder Yes No
- f) skin disorder Yes No
- g) chronic fatigue syndrome Yes No

9. CANCER

- a) cancer Yes No
- b) tumor Yes No
- c) abnormal growth Yes No
- d) carcinoma in situ Yes No

10. BEHAVIORAL HEALTH

- a) attention deficit disorder Yes No
- b) psychological disorder Yes No
- c) suicide attempt Yes No
- d) eating disorder Yes No

11. OTHER

- a) organ or other type of transplant or implant Yes No
- b) breast disorder Yes No
- c) lupus Yes No

- G. Within the last 5 years, has anyone named in this application to be covered by this insurance had any other injury, illness or treatment for any condition not already listed; been hospitalized or been scheduled for hospitalization; had surgery or had surgery scheduled; had a test or a test scheduled; or 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
- H. In the space below please list and provide the complete details if you answered "Yes" above to any of the questions or conditions contained in sections A through G. (Attach additional pages as needed and sign the additional pages.)

Question Number	Name of Person	Date(s) of Treatment	Give full details for each question answered "Yes," state the condition, duration and degree of recovery.	Name and address of attending physician or other health care provider.

- I. If anyone named in this application is taking medication or has had prescribed or recommended any medication during the period of time related to your answer (i.e. past 5 years, past 10 years, or currently taking), please list all those medications, dosages, and what medical condition is being treated or were treated by each medication in the space provided below. (Attach additional pages as needed and sign the additional pages.)

Name of Person	Name, dosage and frequency of medication (include illness or health condition for which medication was prescribed)	Date(s) medication taken (indicate if ongoing)	Name and address of prescribing physician or licensed health care provider and dispensing pharmacy

V. WAIVER OF COVERAGE

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 (check the box that applies):

- Waiving for myself Waiving for my spouse Waiving for my dependent child(ren)
- Waiving for me, my spouse and my dependent child(ren)

I am waiving group health insurance because (check all that apply):

- I, the employee, am covered or will be covered under another plan that is not sponsored by my employer. I am **not** enrolled for coverage under the Health Insurance Risk-Sharing Plan (HIRSP). If currently covered, please attach a copy of your identification card for that plan.
- I, the employee, do not have a risk characteristic or other attribute that would be the sole cause for the small employer insurer to make a decision with respect to premiums or eligibility for a policy that is adverse to the small employer.

Employee Name _____

- My spouse is covered or will be covered under another plan that is not sponsored by this employer. My spouse is **not** enrolled for coverage under the Health Insurance Risk-Sharing Plan (HIRSP). If currently covered, please attach a copy of your spouse's identification card for that plan.
- My dependent child(ren) is covered or will be covered under another plan that is not sponsored by my employer. My dependent child(ren) is **not** enrolled for coverage under the Health Insurance Risk Sharing Plan (HIRSP). If currently covered, please attach your identification card for that plan. Please list, below, the name(s) of the child(ren) for whom coverage is being waived.
- I am **not** enrolled under the Health Insurance Risk-Sharing Plan (HIRSP) and 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**.
- Other reason (Please provide a written reason for waiving coverage):

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 my dependent child(ren). I understand that by signing this waiver, I, my spouse, and 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) may be treated as a late enrollee and subject to postponement or an exclusion of coverage for preexisting conditions for a period of up to 18 months. This period may be offset by the time I, my spouse or my dependent child(ren) was covered under a qualified health plan.

I understand that if I am declining enrollment for myself, my spouse, or my dependent child(ren) because of other health insurance coverage, including Medicaid, 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 30 days after my other health coverage ends or 60 days after Medicaid 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 my dependent child(ren), provided that I request enrollment within 30 days after the marriage, birth, adoption or placement for adoption. If I am declining enrollment for myself, my spouse or my dependent child(ren) because of coverage under Medicaid, I understand that if I, my spouse or my dependent child(ren) become eligible for group health plan premium assistance under Medicaid, I may be able to enroll myself, my spouse or my dependent child(ren), provided I request enrollment within 60 days of initial eligibility for the premium assistance. I understand that I can obtain enrollment information from my employer or small employer group health insurance carrier.

Signature of Employee: _____ Date Signed: _____

VI. MEDICARE INFORMATION

If you need to complete this section for more than one person, **please use a separate sheet of paper and attach it to this application (please sign and date the additional sheet).**

Are you, your spouse or your child(ren) covered by Medicare Part A? Yes No Medicare Part B? Yes No Medicare Part D Yes No
 Name of person covered by Medicare: _____

If "Yes," reason for Medicare: Over Age 65 Disability End-Stage Renal Disease (ESRD) Disability and ESRD

Medicare Part A Effective Date: _____ Medicare Part B Effective Date: _____

Medicare Part C (Medicare Advantage) Effective Date: _____ Medicare Part D Effective Date: _____

VII. CURRENT AND PREVIOUS COVERAGE

The information you provide about your other individual or group health insurance coverage (either prior or current) is necessary to determine whether you will have any waiting periods for preexisting conditions under the group health insurance plan under which you are applying for coverage. Your information will also help the small employer insurer(s) to coordinate benefits with any other group health coverage you may have. By providing this information you are not reducing your group health insurance for which you are applying.

Do you, your spouse or your dependent child(ren) listed in this application have current health insurance coverage or had previous health insurance coverage within the last 18 months? Yes No

If "Yes," please complete the following table and attach a copy of the Certificates of Creditable Coverage for each person.

Starting with you, the employee, identify each person applying for insurance and include information for all current and previous health insurance coverage(s) in effect during the last 18 months.

Employee Name

Name	Insurance Company, Plan & Group Number	Effective Date of Coverage (mo/day/yr)	Termination Date of Coverage (mo/day/yr)	Reason for Termination of Coverage	Type of Coverage (see key below)

Type of Coverage Key: G = Group Comprehensive Major Medical; I = Individual Comprehensive Major Medical; M = Medicare Supplement; D = Drug Coverage Only; H = Hospital Coverage Only; V = Vision Coverage Only

VIII. HEALTH PROVIDER OR PRODUCT SELECTION, IF APPLICABLE

This section should be completed only if the small employer group insurance for which you are applying requires the selection of a network, primary care provider or clinic. If applicable, it should also be used to select the product options offered by the employer or insurer. With respect to the provider or network selection, a selection should be made for each individual applying for such coverage and for each insurer from which insurance coverage is being sought. The provider numbers may be listed in the provider materials (i.e., directory) that are supplied by each insurer to your employer. The provider numbers for the same provider may not be the same for different insurers or products. **Use additional sheets if necessary.**

Insurer: _____
 Product Type: _____
 Coinsurance Option: _____ Deductible Option: _____ Copayment Option: _____
 Selected Provider is for (choose only one): Health Insurance Dental Insurance Other _____

Covered Person's Name	Network or Provider's Name or Number	Is this your current provider?

Insurer: _____
 Product Type: _____
 Coinsurance Option: _____ Deductible Option: _____ Copayment Option: _____
 Selected Provider is for (choose only one): Health Insurance Dental Insurance Other _____

Covered Person's Name	Network or Provider's Name or Number	Is this your current provider?

IX. NON-HEALTH INSURANCE COVERAGE SELECTION, IF APPLICABLE

Availability of coverage is determined by your employer and whether the coverage is approved for issuance by the insurer(s). Please list the insurer(s) below from whom you are applying for coverage and check all benefits for which you are applying. If you have been given a choice of plans to apply for, or if the coverage you are applying for requires the selection of a primary care provider/clinic/network, please complete the section entitled "Provider and/or Product Selection." If you are waiving application for any coverage on yourself and/or your spouse and/or dependent child(ren), please complete the "Waiver of Coverage" section at the end of this section.