Physicians Plus

Group Enrollment/Change Form

2650 Novation Parkway
Madison, WI 53713

I. Employee Information (Please type or print in ink)

☐ New ☐ Change ☐ Cancel All Coverage | Applicant (First Name, MI, Last Name) | Gender: ☐ Male ☐ Female | ☐ Single ☐ Married ___/___/____ ☐ Divorced___/___/____

Street Address | City, State | Zip Code | Birthdate | Best Phone#: (   )

Social Security # | Email Address | Are you disabled? ☐ No ☐ Yes | Ethnic Group

Please select your plan type. Consult your employer if multiple plans are offered: ☐ HMO ________________ ☐ POS ________________ ☐ PPO ________________

I am **WAIVING** coverage: ☐ No ☐ Yes - skip to section 6 | PCP Choice: Name: ________________ Location: ________________ Are you a current patient? ☐ No ☐ Yes

2. Family Information and Primary Care Physician (PCP) Selection

Full Name of Members to be Covered	Relationship	Gender (M/F)	Social Security #	Birthdate	Does he/she have a disability?	PCP Choice: Name/Location (call 608-282-8900 or 800-545-5015)	Are you a current patient of this PCP?
Spouse	Spouse DP						☐ No ☐ Yes
Dependent							☐ No ☐ Yes
Dependent							☐ No ☐ Yes
Dependent							☐ No ☐ Yes

If dependents listed above reside at a different address, please list their name(s) and address(es):

3. Other Health Insurance Information

Do you or any of your dependents receive Workers Compensation benefits? ☐ No ☐ Yes, member's name:

On the day your Physicians Plus coverage begins, will anyone listed on this application be covered by other insurance: ☐ No ☐ Yes | Is coverage a retirement plan? ☐ No ☐ Yes

Name of Insured: | Employer of Insured: | Insurance Company: | Address:

Dependents Covered: | Policy Number: | Policy Coverage Dates (Effective to Term):

List anyone named above who is eligible for Medicare: | **Reason** ☐ Over 65 ☐ Kidney Failure ☐ | Circle Medicare Part: A, B or D Effective Date: | Medicare Number:

4. Authorization Signature to Obtain or Release Medical Information

On behalf of myself and my eligible dependents, I hereby agree to the terms and conditions of enrollment and to the authorization to obtain or release medical information, which appears above and on the reverse side of this application.

Applicant Signature: **Date:** **Spouse/Partner Signature (if applicable):** **Date:**

5. For Employer Use Only

Date of Hire: ____________ | ☐ **New Hire** Effective Date: ____________ | Is employee currently working? ☐ No ☐ Yes | Weekly Hours: | Group/Division #:

☐ **Change** ☐ Marriage/DP ☐ Elect Continuation/COBRA ☐ Add Dependents above ☐ Cancel dependents above ☐ Details/Other: ________________ (adoption, PT to FT, etc.)

☐ **Loss of Coverage** – Prior Carrier Name & Phone# ____________________________ | Date of Special Enrollment: | Effective Date of Change:

Name of Employer: | Email Address: | Phone: (   ) | Approved by: | Date:

6. Waiver of Insurance

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:
☐ Waiving for myself and my eligible dependents ☐ Waiving for my spouse/domestic partner ☐ Waiving for my dependent child(ren)

Reason for waiver: ☐ Persons listed have other insurance: Policy Holder: ____________ Carrier Name: ____________ Policy #: ____________ Effective Date: ________
☐ My out-of-pocket premium contribution would be more than 10% of my annualized income ☐ My eligible dependents live outside the country ☐ Good health

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Should I desire to apply for this insurance in the future, I realize that I may be subject to a waiting period of up to 18 mo. unless I decline due to other coverage and a special enrollment occurs. I certify that this waiver was signed voluntarily and in no way did anyone coerce me into waiving coverage.

Employee signature: **Date:**