Physicians Plus

Group Enrollment/Change Form

2650 Novation Parkway
Madison, WI 53713

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

☐ New ☐ Change	Applicant (First Name, MI, Last Name)	Gender: ☐ Male ☐ Female	Social Security #	☐ Single ☐ Married ☐ Divorced

Street Address	City, State	Zip	County	Phone

Are you disabled? ☐ No ☐ Yes:	Ethnic group	Preferred language (if not English)	Email	Birthdate

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						☐ 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 (If yes, complete below)

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 ☐ Disability	Medicare Part: A, B, C 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:	Effective Date:	Is employee currently working? ☐ No ☐ Yes	Weekly Hours:	Group/Division #:

☐ New Hire ☐ Loss of Coverage ☐ Family Status Change ☐ Cancel all Coverage ☐ Other:	Date of Special Enrollment:	Effective Date of Change:

Reason for Change: ☐ Elect Continuation/COBRA ☐ Add Dependents listed above ☐ Delete dependents listed above ☐ Other:

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

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:**

ACCEPTANCE / AGREEMENT
Group Applicant

By signing this application, I understand and agree that: a) All statements and answers are complete and true to the best of my knowledge and belief; b) The insurance I hereby apply for will be effective only when Physicians Plus Insurance Corporation (Physicians Plus) approves this application, and evidence of such approval will be issuance of the Medical Certificate in accordance with the group master policy; c) I hereby designate the group policyholder as my remitting agent; and d) I authorize Social Security Number use for identification purposes.

I understand that my employer, not Physicians Plus, represents me, my spouse and my legal dependents and my employer acts as my/our sole agent for any and all purposes. I understand that any insurance agent, broker or my employer cannot modify, waive or change in any way this application, any requirement imposed by Physicians Plus, bind coverage or guarantee approval of this application. I further understand and agree that Physicians Plus, its directors, officers, employees and agents shall not be liable for any injury, damage or expense (including attorneys' fees), I, and/or my spouse and/or any of my dependent(s) suffer as a result of any improper advice, action or omission on the part of any health care provider.

Authorization to Obtain and Release Medical Information

By my (our) signature on this application, I (we) authorize: (1) any physician, medical practitioner, hospital, clinic, medically-related facility or other institution who provided treatment or service to me, my spouse and/or my legal dependent(s) listed on the front of this form (to the extent permitted by law) at any time, or their agent(s) (including billing service), having medical information that includes, but is not limited to, identification, medical history, diagnosis, prognosis, consultations, advice, treatments, services, dates of treatments and/or services, test results (excluding any HIV antibody test or genetic test results, but including x-rays) or summary reports, without limitation to period of treatment, diagnostic or therapeutic information, history or type of injury or illness (including pregnancy) and treatment or service, if any, for mental or nervous conditions (excluding psychotherapy notes as defined by law), alcohol or drug abuse, including all programs in which the patient has been enrolled as an alcohol or drug abuse patient; and (2) any insurance or reinsuring company, service or prepaid benefit plan, plan administrator, consumer reporting agency, employer or personal or business associate having non-medical information about me, my spouse and/or my minor child(ren); to disclose to Physicians Plus or their representative(s) (including claims and underwriting departments) all such information (including photographic copies thereof).

I understand that said information will be used by Physicians Plus to determine eligibility for coverage, evaluate and audit claims and determine availability of benefits under the Physicians Plus group health insurance policy, benefit plan or other contract, if issued by Physicians Plus to my employer. I agree that Physicians Plus may release said information to its representative(s) or other person(s) or organization(s) performing business or legal services in connection with my claim(s) or the claim(s) of my spouse and/or my dependent(s) or as may be otherwise permitted by law or as I may further authorize from time to time.

I further authorize Physicians Plus at its option to furnish and deliver to my employer and/or group policyholder or its representative(s) in accordance with the Physicians Plus group health insurance policy, non-identifying personal health information related to the cost of treatments and/or services, payment(s) made for treatments and/or services, dates of said payment(s), and recipients of said payment(s). I understand that the purpose and/or need for such disclosure is for said person(s) to promote health and wellness within the group policy, evaluation of policy premium fluctuation, utilization management and/or the transfer of claims administration.

I understand that I will receive a copy of this authorization. I understand that I have the right to inspect or copy the personal health information to be used or disclosed by Physicians Plus. I understand that this authorization is revocable upon advance written notice given to Physicians Plus at its office in Madison, Wisconsin, except that any information released in reliance thereon and prior to such revocation cannot be retrieved and Physicians Plus and its directors, officers, employees and agents shall not be held responsible or liable for such release.

I understand that Physicians Plus may not condition treatment, payment, enrollment or eligibility for benefits on the provision of this authorization. I also understand that I may refuse to sign this authorization; however, in doing so, Physicians Plus may condition payment of claims and services as permitted by law. I understand that this authorization will remain valid for up to thirty months from the date I or my legal representative execute this authorization or, if longer and permitted by law, for so long as the policy is in force under Physicians Plus. I further understand that a photographic copy of this authorization is as valid as the original.

I understand that I may obtain a detailed description of Physicians Plus's Notice of Privacy Practices from the Physicians Plus Web Site or I may obtain a copy by contacting Physicians Plus Insurance Corporation directly.

Signature of this Agreement does not authorize the use or disclosure of information which is prohibited under Section 631.90 Wisconsin Statutes as it relates to provisions concerning HIV or the use or disclosure of information which is prohibited under Section 631.89 Wisconsin Statutes as it relates to genetic tests.

I understand and acknowledge that any person who, with intent to defraud or knowledge that the person is facilitating a fraud against an insurer, 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 other person, conceals significant information from an application or claim is committing a fraudulent act.