Employee Application for Small Group Coverage

Applications must be submitted within 60 days of the date you become eligible for coverage.
Your group may have a waiting period before coverage becomes effective.

Employer Name: ______________ **Group Number:** ______________ **Requested Effective Date:** ______________

Employee Plan Selection: ☐ HMO ☐ POS ☐ PPO **Employee Status:** ☐ Full-time *(>30 hours/week)* ☐ Part-time *(<30 hours/week)* ☐ Seasonal

Your Information (Employee Subscriber)

Employee Name (Last, First, Middle)

Street or Post Office Address | *City* | *County* | *State* | *Zip Code*

Home Phone Number | *Work Phone Number*

E-mail address | *On average, how many hours do you work each week?*

Are you: ☐ Single ☐ Married ☐ In a domestic partnership ☐ Divorced ☐ Legally separated
☐ Widow or Widower Date of occurrence: ______________

Date of hire:

Are you retired: ☐ Yes ☐ No
Are you Medicare Eligible: ☐ Yes ☐ No
Other: ☐ ______________

Are you on COBRA or State Continuation? ☐ Yes ☐ No If so, please provide start date and reason: ______________

Coverage information (please check appropriate box indicating the reason for submitting application)

- ☐ New Hire
- ☐ Loss of other coverage
- ☐ Late applicant
- ☐ Rehire
- ☐ Return from layoff
- ☐ Annual dual choice / open enrollment
- ☐ Transfer to disability segment
- ☐ Transfer to retiree segment
- ☐ Part-time to full-time employment
- ☐ Election for continuation
- ☐ Marriage
- ☐ Birth, adoption / placement for adoption
- ☐ Add/delete dependents
- ☐ Name change / address change / PCP change
- ☐ Other

When did this event occur? (MM/DD/YY) ______________

Please select the type of insurance coverage for which you are applying:
☐ *Employee only* ☐ *Employee and spouse/domestic partner* ☐ *Employee and dependent child(ren)* ☐ *Employee, spouse/domestic partner and dependent child(ren)*

Name (Last, First, Middle)	Relationship to Employee	Social Security #	Date of Birth	Gender	Primary Care Provider/Clinic
	Self				
	Spouse/domestic partner				
	☐ *Child* ☐ *Stepchild* ☐ *Other:* ______				
	☐ *Child* ☐ *Stepchild* ☐ *Other:* ______				
	☐ *Child* ☐ *Stepchild* ☐ *Other:* ______				
	☐ *Child* ☐ *Stepchild* ☐ *Other:* ______				

Your dependents

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

____

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 the name of the person who has primary custody of the dependent child(ren) and the name of the responsible person for health insurance: ______________

Are you a spouse or child(ren) covered by Medicare Part A, Medicare Part B, or Medicare Part D? ☐ Yes ☐ No
If "yes, please list name(s): ______________

Reason for Medicare: ☐ Age 65 ☐ Disability ☐ End Stage Renal Disease ☐ Disability and End Stage Renal Disease

Part A Effective Date: ________ *Part B Effective Date:* ________ *Part C (Med Advantage) Effective Date:* ________ *Part D Effective Date:* ________

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:

Name	Insurance Company, Plan & Group Number	Effective Date of Coverage	Termination Date of Coverage	Reason for Termination of Coverage	Type of Coverage

Option to Waive Coverage

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* ☐ *Waiving for spouse/domestic partner* ☐ *Waiving for my dependent child(ren)* ☐ *Waiving for myself, my spouse/domestic partner and my dependent children*

Reason for Waiver: ☐ *Persons listed above have other credible coverage (Name of Carrier:* ______________ */ Effective Date:* ______________*)* ☐ *Good health*
☐ *My earnings are such that I would have to pay more than 10% of my annualized gross earnings toward health insurance* ☐ *Other*

Employee Signature: ______________ *Date signed:* ______________

Spouse/Domestic Partner Signature: ______________ *Date signed:* ______________

Terms and Conditions

1. By signing this Application, I understand and agree that:

(a) all statements and answers I have given 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 approves this Application. Evidence of such approval will be the issuance of ID Card(s), which will be delivered to the group and/or employee;

(c) if my eligibility or employment status has changed from what is indicated on the Application prior to the effective date of coverage, I will notify Physicians Plus of the change immediately. Changes in eligibility or employment status prior to the effective date of coverage, but not reported to Physicians Plus, will be considered misstatements. Any person who knowingly presents a false or fraudulent claim within the contestable period 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/or imprisonment under Wis. Stat. 943.395. I further understand that, in the event of fraud or misrepresentation, this information may be used to reduce or deny a claim, void coverage, or void the group contracts within the contestable period, if such misrepresentation affects Physicians Plus' acceptance of risk.

2. By my signature on this application, I authorize:

(a) Any physician, medical practitioner, hospital, clinic, medically related facility or other institution who provided treatment or service to me, my spouse or my minor child(ren) at any time, or their agent(s) (including billing service), having medical information which includes, but is not limited to, identification, medical history, diagnosis, prognosis, consultations, advice, treatments, services, dates of treatments and/or services, test results (excluding genetic tests and FDA-licensed blood tests for the presence of HIV, but including X-rays), 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, alcohol abuse or drug abuse), and

(b) Any insurance or reinsuring company, service or prepaid benefit plan, plan administrator, consumer reporting agency, employer or personal or business associates having non-medical information about me, my spouse, or my minor child(ren), concerning eligibility and claim administration to disclose to Physicians Plus, or their representatives (including the claims department) all such information. I understand that when used for the purposes of obtaining information in connection with claims for benefits, utilization review, quality improvement, health care operations or other activities as permitted by law, this Authorization is valid during the Policy term or pendency of the claims for benefits, whichever is longer. I understand that I may request and receive a copy of this authorization.

3. I understand that any approved coverage is not effective for me or my dependents if I am not actively at work at my full-time employment with my employer on the assigned effective date, but that such coverage will first become effective on the first day thereafter that I am actively working at such employment.

4. This Application, when approved, and any endorsement, amendment, or rider thereto, will be made part of the contract(s) applied for.

5. No person, except an officer of Physicians Plus Insurance Corporation, is authorized to vary or modify a contract. 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 attorney's fees) that I or any of my dependents suffer as a result of any improper advice, action, or omission on the part of any health care provider.

6. Subject to the acceptance of the Application by Physicians Plus, I authorize the group, as my remitting agent and until this authorization is revoked in writing, to deduct from my wages or salary a sufficient amount to provide for the regular and timely prepayment of the prevailing subscription fees that are not otherwise contributed by my employer for the contract(s) applied for and to remit the same on my behalf to Physicians Plus.

7. The contract(s) applied for will become void if and when I cease to be employed or affiliated with the group. Should I wish to retain my membership after such termination, it shall be my responsibility to secure a new application form from Physicians Plus and to apply for the programs then being offered to such individuals.

8. I understand that Physicians Plus operates multiple disease and population management programs and communicates a variety of information to members in order to advise of new services to help one stay healthy and best manage the care I receive. I understand I may be contacted regarding these programs and my preferred method of contact is:

☐ Email. Physicians Plus will never send your protected health information using unsecured email. If you receive our newsletters and other communications by email, please know that email is not a secure form of communication.

☐ Telephone. We will use the primary number on this application unless you specify here: ____________________

☐ U.S. Mail. We will use the primary address on this application unless you specify here: ____________________

I understand and agree to the terms and conditions listed on this application. A copy of this application is as valid as the original. I authorize Physicians Plus, on behalf of myself and my dependents, to obtain or release medical information as set forth above. I certify that the plan benefits have been explained to me and I am fully aware that benefits may be reduced if I or an insured family member fails to follow any applicable requirements of the plan.

Employee Signature: ____________________ Date signed: ____________________

Spouse/Domestic Partner Signature: ____________________ Date signed: ____________________

Signature of each dependent child who has attained the age of 18

Dependent Signature: ____________________ Date signed: ____________________

Dependent Signature: ____________________ Date signed: ____________________

Dependent Signature: ____________________ Date signed: ____________________

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