GROUP HEALTH COOPERATIVE OF SOUTH CENTRAL WISCONSIN (GHC-SCW) INDIVIDUAL SUPPLEMENTAL APPLICATION FORM

PLEASE COMPLETE THIS APPLICATION. These forms are used to determine acceptability for health care coverage. Applicants may be rejected if their health status does not meet the GHC-SCW medical underwriting criteria. If medical records are needed to further determine acceptability, you will be asked to furnish them at your own expense.

This application is a legal document. It is important that you fill it out completely and correctly in order for you and your family to receive proper and timely coverage. An incomplete application will delay the application process and your access to clinical appointments and services. If you submit your application and payment by mail, please make sure the Individual Plan Supplemental Application is filled out completely and signed.

Do not cancel your current health coverage. The enrollment process generally takes one to two weeks. We will promptly notify you regarding your acceptance or rejection into the GHC-SCW Individual Plan. **Coverage is effective on the first of the month** following approval of your application; coverage for all plan benefits begins at that time.

All plans renew with rate adjustments on January 1st of the following year of the effective date of policy.

Payment Method
Please submit your payment for the first month's coverage along with your application. If you are not accepted for coverage, your payment will be returned.

You may pay with a personal check or money order. GHC-SCW will not accept payment with a business check. If you would like to preauthorize your monthly payments, please complete the enclosed "Authorization Agreement for Preauthorized Payment" form. GHC-SCW will still require a check for the first month's coverage.

Failure to pay your Individual Plan premium by the due date could result in termination of coverage.

To receive information about covered services or for questions regarding the Individual Plan application process, call the GHC-SCW Marketing Department at (608) 251-3356.

Please list as the Primary Applicant/Insured the individual who has the earliest date of birth under section one on the Uniform Application. The policy will be issued to the individual who has the earliest date of birth. If, during any time this policy is in effect, a dependent spouse is added whose date of birth is earlier than the currently listed Primary Applicant/Insured, the dependent spouse will be then be listed as the Primary Applicant/Insured and rates will be based upon this dependent spouse. Revised rates will be effective on the date the dependent spouse is added.

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Plan Options:				
Co-pay	☐ $15 Co-pay	☐ $20 Co-pay	☐ $30 Co-pay	☐ $40 Co-pay
Deductible	☐ $500 Deductible		☐ $1,000 Deductible	
High Deductible		☐ Plan A- $1,200 Deductible		☐ Plan B- $1,200 Deductible
☐ Plan C- $2,500 Deductible		☐ Plan D- $2,500 Deductible		☐ Plan E- $5,250 Deductible
Benefit Arch	☐ $2,000 Benefit Arch		☐ $3,000 Benefit Arch	

Rider Option:
☐ Drug Amendment

(Check box to apply for prescription coverage)

Drug Amendment is available on these plans.

☐ I understand that my application may not be accepted if the Health Status does not meet the GHC-SCW medical underwriting criteria. If my application were not accepted for the sole reason for prescription drugs, by checking this box, I agree to enroll in the same plan options without prescription drug coverage.

Requested Effective Date or Effective date of Change______________

Coverage is effective on the first of the month following approval of your application; coverage for all plan benefits begins at that time.

Reason for Application

1. New Application______
2. Change _____ Reasons for change:

☐ Adding Dependent ☐ Deleting Dependent ☐ Termination of the policy
☐ Name Change ☐ Address Change ☐ Change Plan Options

Please select one of the following Race/Ethnicity Categories that best identifies you.

☐ American Indian or Alaskan Native ☐ Asian ☐ Black or African American
☐ Native Hawaii or Other Pacific Islander ☐ White ☐ Other________________

GHC-SCW would like to provide your medical care in your language of choice.
What is your language of choice? ____________________________________

Select a Primary Care Provider / Clinic (Please Note: If we find while processing your subscriber application that you did not select a Primary Care Provider (PCP) for yourself or your dependents, or that you selected a PCP who is not accepting new patients, GHC-SCW will assign you and/or your dependents to an available PCP based on your age, gender and mailing address. The assigned PCP will be printed on your ID card at the time of enrollment. Please visit ghcscw.com and choose the "Provider Search" to view available providers.)

Name	**Provider Name**	**Clinic Location**

Have you or any listed dependent ever been an enrollee at GHC-SCW?
☐ Yes ☐ No. If yes, please list names & member numbers

____

In the last 5 years, have you or any dependents had medical coverage denied, rated-up or had an exclusion placed on policy? ☐ Yes ☐ No

Authorization of Medical Information

I hereby apply to Group Health Cooperative of South Central Wisconsin (GHC-SCW) for enrollment as an individual plan subscriber. I understand that non-emergency services of GHC-SCW are available only at specified locations and when ordered or approved by a GHC-SCW physician, if necessary; I authorize any physician, hospital or other provider of health services provided to me or any of my enrolled dependents. To the best of my knowledge, all statements and answers in this application are complete and true.

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. I understand that any material misstatement in the Individual Uniform Application for Individual Major Medical Health Insurance Form may result in denial of a claim and/or rescission of coverage. I understand that any additional pages attached to this application are considered part of the application and are subject to this same agreement.

B) The insurance I hereby apply for will be effective only when GHC-SCW approves this application. Evidence of such approval will be issuance of the contract or policy. The effective date will be the date indicated by GHC-SCW.

I authorize any health care provider, including physicians, clinics, hospitals, Medical Information Bureau, Inc. or other institutions named in the application for insurance or who attends or has attended me, my spouse or any of my children, at any time, to disclose to GHC-SCW information from any health care record for a person applying under this policy. I understand this could include, but is not limited to identity, medical history, diagnosis, prognosis, date of treatment, treatment test results, and summary reports. I also understand that this consent is revocable except to the extent that action has been taken in reliance thereon, and that consent will remain in force for two and one-half years in order to effectuate the purposes for which it is given. Further, I acknowledge that all members covered under my policy allow GHC-SCW to use personal health information for treatment, coordination of care, quality assessment and measurement, including member surveys, accreditation, billing and other legitimate, appropriate purposes of this nature for the purposes of treatment, payment and health care operations. I understand that when GHC-SCW transmits personal health information to people and organizations outside of GHC-SCW they may do so electronically or by other means; aggregated or blinded data is submitted if personal identification is not required for conducting GHC-SCW business. A photocopy of this authorization is as valid as the original.

SIGNATURE____ **DATE** ___________________________

SPOUSE'S SIGNATURE____ **DATE**___________________________

GROUP HEALTH COOPERATIVE OF SOUTH CENTRAL WISCONSIN (GHC-SCW)
INDIVIDUAL SUPPLEMENTAL APPLICATION FORM

To apply for coverage please complete these steps.

______ 1. Complete Individual Uniform Application for Individual Major Medical Health Insurance Form.

______ 2. Complete Group Health Cooperative of South Central Wisconsin (GHC-SCW) Supplement Application Form

______ 3. Submit Premium Payment- for the first month premium, include:

a. Personal Check
b. *Authorization Agreement for Preauthorized Payment* – (Only complete if you would like initial or monthly premiums to be paid automatically to GHC-SCW.) If completing for checking account, a check for the first month's premium must be included.

Please mail the items to Group Health Cooperative of South Central Wisconsin (GHC-SCW):

Group Health Cooperative of South Central Wisconsin
Attn: Individual Plans
1265 John Q Hammons Drive, Suite 200
Madison WI 53717

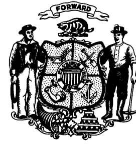
--- For Office Use Only ---

Agent Information	
Agent Name:	Agent Number:
Agency Name:	Agency Number:
Signature:	Date:

GHC-SCW Administrative Information
Group Number:
Date Received:
Effective Date:
Contract Type:
Transaction Type:
Check Number:
Check Amount:

INDIVIDUAL UNIFORM APPLICATION FOR INDIVIDUAL MAJOR MEDICAL HEALTH INSURANCE FORM

Ref: Section Ins 3.33, Wis. Adm. Code, and s. 601.41 (10), Wis. Stat.



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

This form is designed for an individual's initial application for coverage. Please contact the insurer with questions regarding this form.

Instructions: Please complete the entire application for each person for whom coverage is being sought. If a person is currently enrolled in Medicare, this application should not be completed for that enrolled individual. If additional pages are needed to fully complete this application, please attach, sign and date each page.

I. INFORMATION

Primary Applicant/Insured Information:

First, Middle and Last Name				
Social Security No.*	Place of Birth	Birth Date	Gender	Height ______ Weight ______
Residential Address				

City	County	State	Zip Code
Mailing Address, if different from residential address			
City	County	State	Zip Code
Home Phone	Alternative Phone		Email (Optional)

*If you have a Social Security Number.

The Primary Applicant is:

[ ] Single [ ] Married [ ] Under the age of 18**

**If primary applicant is under the age of 18, please complete sections – II. C. and V.

Employment Information:
Primary job duties:

Self-Employed: [ ] Yes [ ] No

II. ADDITIONAL APPLICANTS

A. Please complete ONLY if your spouse and/or children under the age of 27 are applying for coverage. If there is not enough space provided, please attach additional family information. **Please sign and date the additional sheet.**

Spouse Name (First; M.I.; Last)	Gender	Social Security Number*/ Place of Birth	Birth Date (Mo/Day/Yr)	Height Weight	Primary Job Duties (if applicable)

* If you have a Social Security number.

Child Name (First; M.I.; Last)	Gender	Social Security Number*	Birth Date (Mo/Day/Yr)	Height Weight	Primary Job Duties (if applicable)

* If you have a Social Security number.

B. Does the child(ren) named within this application live with you at the address shown above?

[ ] Yes [ ] No If "No," please list the child(ren)'s name and mailing address(es):

Mailing Address Named Applicant			
City	County	State	Zip Code
Home Phone		Alternative Phone	
Name of the Legal Guardian or Parent responsible for carrying health insurance for the minor child.			

C. If the primary applicant is under the age of 18, provide the name and mailing address of the legal guardian or custodial parent:

Mailing Address Legal Guardian or Custodial Parent			
City	County	State	Zip Code
Home Phone		Alternative Phone	
Name of the Legal Guardian or Parent responsible for carrying health insurance for the minor child			

III. CURRENT AND PREVIOUS COVERAGE

Please provide information about you or your dependent's individual or group health insurance coverage or other health coverage (either prior or current). It will help us determine whether you will have any waiting periods for preexisting conditions for the health insurance you are applying for. By providing this information you are not reducing your health insurance.

Does anyone applying for coverage have current health coverage?
[ ] Yes [ ] No If "Yes," please indicate insurer and applicant ________________________.

Has any applicant had health insurance coverage within the last 18 months?
[ ] Yes [ ] No If "Yes," please indicate insurer and applicant_______________.

If any applicant has current health coverage, will that applicant cancel current coverage if this applicant is accepted?
[ ] Yes [ ] No

Is any applicant enrolled in Medicare?
[ ] Yes [ ] No If "Yes," name of applicant ___________________. For this applicant, please stop here – this insurance may duplicate existing Medicare coverage.

Is any applicant enrolled in Medicaid or other governmental health programs (i.e. BadgerCare, TRICARE, Veterans services)?
[ ] Yes [ ] No If "Yes," name of applicant ____________________. For this applicant, please be aware that obtaining individual health insurance may affect this individual's Medicaid status.

IV. MEDICAL INFORMATION

NOTICE TO APPLICANT:

The 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. For the purpose of these questions, *chronic* means persistent, continuous, or periodic, or a combination of any of these terms.

You are required to disclose information regarding any disease or condition for which:

- Any applicant has been diagnosed or treated by any healthcare provider.
- Any applicant has had testing with abnormal results.
- Any applicant is awaiting test results.
- Any applicant has been recommended or scheduled for diagnostic testing, consultation, treatment, follow-up, or surgery.
- Any applicant has taken or has been advised to take any prescription medication.
- Any change in health status for which any applicant has not sought medical care or treatment.

Within the last FIVE (5) YEARS has anyone, including you or any family member requesting coverage, received counseling, care or treatment, medication, medical advice or been told a diagnosis for any of the conditions or illnesses listed below? (Please check all conditions that apply.)

Please mark "Yes" or "No" for each item, for you and any family members requesting coverage. Provide additional information for each question you answer "Yes" to on the Additional Medical Details page that follows the health questions.

Answers to the medical questions should be complete, true and correct to the best of your knowledge. You are required to promptly notify us if there is a change in your or your family's health prior to the effective date of coverage and provide updated information. If at any time during the underwriting process prior to the effective date of coverage, you or your health history changes, please notify us immediately as this may impact your coverage.

WITHIN THE LAST FIVE (5) YEARS:

1. Infectious and Parasitic Diseases

a. AIDS (acquired immunodeficiency syndrome), ARC (AIDS-related complex), HIV positive [The reporting of HIV test results is limited to FDA-licensed tests, and you need not report results of tests conducted at an anonymous counseling and testing site or through the use of a home test kit.] .... [ ] Yes [ ] No

b. Lyme's Disease	[ ] Yes [ ] No
c. Sexually transmitted disease(s)	[ ] Yes [ ] No

2. Blood, Gland, Endocrine, Metabolic and Immune Disorders (other than HIV, ARC, AIDS)

a. Anemia/blood disorder	[ ] Yes [ ] No
b. Thyroid disease	[ ] Yes [ ] No
c. Diabetes/high or low blood sugar. .... (If "Yes," record last HGA1C reading and date on the Additional Medical Details page.)	[ ] Yes [ ] No
d. Adrenal disorder	[ ] Yes [ ] No
e. Enlargement of lymph nodes	[ ] Yes [ ] No
f. Endocrine/gland/hormone system	[ ] Yes [ ] No

3. Cancer, Cyst and Tumors

c. Cancer. .... (If "Yes," include the stage, type and location of the tumor on the Additional Medical Details page.)	[ ] Yes [ ] No
b. Tumors, cyst, lump, polyp	[ ] Yes [ ] No

4. Mental/Nervous/Behavioral Disorders

a. Alcohol/chemical/drug abuse/dependency	[ ] Yes [ ] No
b. Has any applicant used sedatives; tranquilizers; cocaine or other hallucinogenic or narcotic drugs?	[ ] Yes [ ] No
c. Eating disorders such as, but not limited to, anorexia or bulimia	[ ] Yes [ ] No
d. Mental/emotional condition/depression	[ ] Yes [ ] No
e. Autism	[ ] Yes [ ] No
f. Suicide attempt	[ ] Yes [ ] No
g. Alcohol, chemical, drug abuse therapy, treatment or counseling within last 5 years .... (if "Yes," record date of last session in on the Additional Medical Details page)	[ ] Yes [ ] No

5. Brain and Nervous System

a. Brain disease or injury/concussion	[ ] Yes [ ] No
b. Convulsion/seizures/epilepsy	[ ] Yes [ ] No
c. Chronic headaches/migraines	[ ] Yes [ ] No
d. Neurological condition/disease/injury	[ ] Yes [ ] No
e. Sleep apnea/chronic sleep disorder	[ ] Yes [ ] No
f. Stroke	[ ] Yes [ ] No
g. Multiple Sclerosis	[ ] Yes [ ] No
h. Paralysis	[ ] Yes [ ] No

6. Skin Disorders

a. Skin condition, abnormal or cancerous moles or eczema/cysts/cancer	[ ] Yes [ ] No

7. Eyes, Ears, Nose

a. Chronic ear/nose condition/disease	[ ] Yes [ ] No

b. Chronic eye condition/disease	[ ] Yes [ ] No
c. Cataracts/glaucoma	[ ] Yes [ ] No

8. Mouth, Throat or Jaw

a. Chronic throat/tonsil/adenoid/disease/disorder	[ ] Yes [ ] No
b. TMJ/jaw joint	[ ] Yes [ ] No

9. Heart or Circulatory System

a. Blood/circulatory disorder	[ ] Yes [ ] No
b. Heart attack/chest pain/murmur/angina	[ ] Yes [ ] No
c. Elevated/High cholesterol (if "Yes," record last reading and the date on the Additional Medical Details page)	[ ] Yes [ ] No
d. Elevated/High or low blood pressure (if "Yes," record last 3 readings and dates in past 12 months on the Additional Medical Details page)	[ ] Yes [ ] No
e. Phlebitis/blood clot	[ ] Yes [ ] No
f. Heart disease/disorder	[ ] Yes [ ] No

10. Respiratory System

a. Asthma	[ ] Yes [ ] No
b. Emphysema/Chronic obstructive pulmonary disease (COPD)	[ ] Yes [ ] No
c. Chronic respiratory/lung condition	[ ] Yes [ ] No
d. Pneumonia/bronchitis	[ ] Yes [ ] No

11. Digestive System

a. Appendicitis/chronic abdominal pain	[ ] Yes [ ] No
b. Blood in stool	[ ] Yes [ ] No
c. Colon/rectum/intestine/bowel/Crohn's disease	[ ] Yes [ ] No
d. Ulcer/esophageal reflux	[ ] Yes [ ] No
e. Gallbladder	[ ] Yes [ ] No
f. Liver condition/hepatitis/pancreas	[ ] Yes [ ] No

12. Urinary System

a. Bladder/urinary tract	[ ] Yes [ ] No
b. Kidney/kidney stones	[ ] Yes [ ] No

13. Male or Female Reproductive Systems

a. Breast (lumps or masses)	[ ] Yes [ ] No
b. Prostate/elevated PSA/prostatitis	[ ] Yes [ ] No
c. Reproductive system disorder/infertility/dysfunction	[ ] Yes [ ] No
d. Abnormal pap smear or mammography	[ ] Yes [ ] No

14. Pregnancy, Birth or Congenital Abnormalities

a. Birth defect/congenital deformities	[ ] Yes [ ] No
b. Pregnancy complications	[ ] Yes [ ] No

c. 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 ___________.) .... [ ] Yes [ ] No

15. Muscular or Skeletal System

a. Back/neck/spine disorder .... [ ] Yes [ ] No
b. Bone/orthopedic disorder .... [ ] Yes [ ] No
c. Lupus, chronic muscle pain, muscle injury or disease, or fibromyalgia.......... [ ] Yes [ ] No
d. Osteoarthritis/osteoporosis/osteopenia .... [ ] Yes [ ] No
e. Rheumatoid arthritis.......... [ ] Yes [ ] No
f. Knee/shoulder/hip/joint surgery/disorder.......... [ ] Yes [ ] No
g. Hernia .... [ ] Yes [ ] No

16. Miscellaneous

a. Cosmetic surgery/implants .... [ ] Yes [ ] No
b. Use of prosthetic devices/limbs .... [ ] Yes [ ] No
c. Had chronic fatigue .... [ ] Yes [ ] No
d. Is any person to be insured now disabled, on disability, or unable to perform normal work or age-related activities .... [ ] Yes [ ] No
e. Any fluctuations in weight (+/- 20lbs) in the past 12 months .... [ ] Yes [ ] No
f. Implantable devices/stents/shunts/pace maker.......... [ ] Yes [ ] No
g. Allergies .... [ ] Yes [ ] No
h. Transplants .... [ ] Yes [ ] No

17. Other Injury, Illness, Treatment or Condition

a. Within the last 5 years, has any applicant had any other injury, illness, treatment, or condition not already listed; been hospitalized or scheduled to be hospitalized; had surgery or had surgery scheduled; had a test or a test scheduled; been recommended to have a test or surgery that was not performed for any reason not already mentioned; been prescribed medication for a condition or injury not already mentioned? (We are NOT seeking the results of HIV Antibody test.) .... [ ] Yes [ ] No

18. Tobacco Use

a. Has any applicant used tobacco products in any form within the last 12 months? .. [ ] Yes [ ] No If "Yes", provide the name of applicant(s), amount of tobacco used and frequency:

19. Other Activities

a. Has any applicant been involved in or participated in organized motorized racing or other extreme activities? .... [ ] Yes [ ] No If "Yes", provide the name of applicant(s), activity and frequency of the activity:

ONLY complete this section if you need assistance with completing the medical information portion of this Application. Please note that this may require additional time to process your application.

Please contact me at this phone number during business hours:

I am unavailable during business hours, please contact me at this number during evenings or weekends:

Additional Medical Details Page

For any "Yes" responses in the medical information questions, please provide complete details below. Not providing complete details will delay the application process. Within the last five years has anyone been prescribed medications that were recommended or received from a licensed health care professional? Use an additional sheet(s) of paper if necessary.

All additional pages must be signed and dated by the primary applicant.

Question # or additional information								
Applicant Name								
Specific Diagnosis & Type of Treatment								
Duration of Condition	**Began mm/yy**		**Began mm/yy**		**Began mm/yy**		**Began mm/yy**	
	End mm/yy		**End mm/yy**		**End mm/yy**		**End mm/yy**	
Name/ Dosage/ Frequency of medication & Dates of Medication Use	**Name of Rx**		**Name of Rx**		**Name of Rx**		**Name of Rx**	
	Dose		**Dose**		**Dose**		**Dose**	
	Began mm/yy	**End mm/yy**	**Began mm/yy**	**End mm/yy**	**Began mm/yy**	**End mm/yy**	**Began mm/yy**	**End mm/yy**
Was surgery performed								
Description of surgery/ Procedures/ Tests/Result & Dates								
Current Status/ O-Ongoing/ R-Resolved								
Readings for Blood Pressure, Cholesterol & Diabetes	**Date**	**Reading**	**Date**	**Reading**	**Date**	**Reading**	**Date**	**Reading**
Physician/ Hospital Name, City, State								

V. TERMS AND CONDITIONS

I acknowledge that I have read and completed the entire Application. If I received assistance in reading or completing this Application, I have identified the person(s) who assisted me. I agree that the answers are, to the best of my knowledge and ability, complete and true.

I understand that my answers, together with any supplements or additional pages, are the basis for the certificate or policy that is issued. I agree that no insurance will be effective until the date specified by the insurance company on the certificate or policy.

I understand that any intentional misrepresentation relied upon by the insurer may be used to deny a claim. I further understand that this contract can be voided if within the first 24 months from the date of the policy or certificate it is determined that I or a family member made an intentional misrepresentation in the application.

I understand that it may be a crime to submit an application or file a claim based on a false or deceptive statement. I further understand it may be a crime to submit an application that is intended to mislead an insurer or conceal significant information about the applicant.

I understand that I may request a copy of this Application and the notice of the company's privacy practices. I agree that a photocopy is as valid as an original. A legible facsimile or electronic signature shall have the same force as the original.

Signature (or e-signature) of Primary Applicant (If Primary Applicant is under the age of 18, Signature of legal guardian or custodial parent)	**Date Signed**
Signature (or e-signature) of Spouse	**Date Signed**

Signature (or e-signature) of each listed child who has attained the age of 18

Signature (or e-signature) of an Adult Child Applicant	**Date Signed**
Signature (or e-signature) of an Adult Child Applicant	**Date Signed**
Signature (or e-signature) of an Adult Child Applicant	**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 the assistant's relationship to you and your family: