

# 2025 Individual Application

Adams, Columbia, Grant, Green, Iowa, Juneau, Lafayette and Sauk Counties

Group Health Cooperative of South Central Wisconsin (GHC-SCW)



## Please Complete This Application

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 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 receipt of the application if the application is received by the 15th of the month. If received on or after the 16th of the month, it will be effective the first of the month following the next month. (Example: if the application is received on December 20th, it would be effective on February 1st.)

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

**Change of residential address may change your rates and benefits.**

## Payment Method

Please submit your payment for the first month's coverage along with your application. You may pay with a personal check, money order or complete the one-time Credit or Debit Card Payment Form.

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** Sales Department at **(608) 828-4831**.

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Group Health Cooperative of South Central Wisconsin (GHC-SCW)

MK22-137-2(8.24)F

\*Affordable Care Act (ACA)



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Please choose one of the following plans for your 2025 Health Insurance Coverage

Plan Name	Plan Type <small>(please only select one option)</small>
<b>Gold Plans</b>	Partners HMO Gold 1000 Ded/6000 MOOP with Vision Partners HMO Gold 1500 Ded/7800 MOOP Partners HMO Gold 2900 Ded/2900 MOOP HSA
<b>Silver Plans</b>	Partners HMO Silver 5500 Ded/5500 MOOP HSA Partners HMO Silver 4100 Ded/7500 MOOP with Vision Partners HMO Silver 5000 Ded/8000 MOOP
<b>Bronze Plans</b>	Partners HMO Bronze 7900 Ded/7900 MOOP HSA Partners HMO Bronze 5000 Ded/9200 MOOP Partners HMO Bronze 7500 Ded/9200 MOOP

Subscriber Full Name \_\_\_\_\_

Requested Effective Date or Effective Date of Change \_\_\_\_\_

All plans begin on the first of the month. See details on the first page.

**Please indicate the reason for submitting this application:**

- New Application
- Change (reasons for change):
  - Adding Dependent
  - Address Change
  - Name Change
  - Termination of the Policy
  - Dropping Dependent
  - Change Individual Plan

**Payment Method**

Select one of the following payment methods for the first month's premium.

- Personal Check (required with application)
- Automatic Payment Authorization (Form A required)

..... OFFICE USE ONLY .....

GHC-SCW Administrative Information		
Date Received	Effective Date	Group Number
Contact Type	Transaction Type	
Check Number	Check Amount	
Agent Information		
Agent Name	Agent Number	
Agency Name	Agency Number	
Signature	Date	

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SECTION ONE - Applicant Information					
Full Legal Last Name	Full Legal First Name	M.I.	Date of Birth <small>(mm/dd/yyyy)</small>	Social Security # <small>(required)</small>	
Residential Address			City	State	Zip Code County
Home Phone _____	Marital Status Single                      Divorced Married                      Other Domestic Partnership		Legal Sex Male Female X	Email Address <small>(providing email address authorizes GHC-SCW to use securely)</small>	
Work Phone _____				Previous Name	
Cell Phone _____					
Tobacco Use* Yes                      No	Primary Care Provider (PCP)/Primary Clinic Choice**				

SECTION TWO - Covered Dependent Information					
Full Legal Last Name	Full Legal First Name	M.I.	Previous Name	Relationship Spouse/Partner Child Other:	Mailing Address <small>(if different than subscriber)</small>
Date of Birth <small>(mm/dd/yyyy)</small>	Social Security # <small>(required)</small>	Legal Sex Male Female X	PCP/Primary Clinic Choice**		Tobacco Use* Yes No
			Email Address		
Full Legal Last Name	Full Legal First Name	M.I.	Previous Name	Relationship Spouse/Partner Child Other:	Mailing Address <small>(if different than subscriber)</small>
Date of Birth <small>(mm/dd/yyyy)</small>	Social Security # <small>(required)</small>	Legal Sex Male Female X	PCP/Primary Clinic Choice**		Tobacco Use* Yes No
			Email Address		
Full Legal Last Name	Full Legal First Name	M.I.	Previous Name	Relationship Spouse/Partner Child Other:	Mailing Address <small>(if different than subscriber)</small>
Date of Birth <small>(mm/dd/yyyy)</small>	Social Security # <small>(required)</small>	Legal Sex Male Female X	PCP/Primary Clinic Choice**		Tobacco Use* Yes No
			Email Address		

\*Tobacco Use is defined as the use of tobacco product or products four or more times per week within no longer than the past six months by legal users of tobacco products (those 18 years of age and older) and includes all tobacco products.

\*\*If you do not select a PCP for yourself and/or your dependents, GHC-SCW will assign you and/or your dependents one.

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## SECTION THREE - Previous Insurance Information (outside the open enrollment period)

Are you applying for coverage outside the open enrollment period? (Please do not list insurance being replaced by GHC-SCW.)

Yes. Complete the following information.

No. Skip to section five.

Health Insurance Name		Health Insurance Phone		
Health Insurance Address	Name of Policyholder		Policyholder Date of Birth <small>(mm/dd/yyyy)</small>	
Termination Date of the Policy	Group Number and Patient ID Number		Employer Name	
Is anyone listed on this application eligible for Medicare coverage? Yes      No		Name of person eligible for Medicare coverage		
Reason ESRD    Disabled    Over 65	Part A (Hosp.) Effective Date	Part B (Med.) Effective Date	Part D (Drug) Effective Date	Medicare Number

## SECTION FOUR - Transition of Care In order to properly transition your care, please provide the following information for all applying for coverage.

Is anyone under the care of the following specialists?

Cardiologist	Endocrinologist	Nephrologist	Neurologist	Oncologist	Rheumatologist
Name of Individual	Specialty Care	Specialty Care Provider Full Name/City/State			
_____	_____	_____			
_____	_____	_____			
_____	_____	_____			

Will anyone have prescriptions that will need refills?      Yes. Please complete the following information below.      No

Name of Individual	Name of Prescription
_____	_____
_____	_____
_____	_____
_____	_____

## SECTION FIVE

What is your language of choice?	Are you Hispanic/Latino? Yes      No      Decline to Answer
Please select category that best describes your race - select all that apply. American Indian or Alaska Native    Asian    Black or African American    Native Hawaiian or other Pacific Islander    White    Decline to Answer	

## SECTION SIX - Signature

My signature on this form represents my agreement to the following Terms and Conditions: (1) The information I have provided is true and correct to the best of my knowledge; (2) I have the proper legal authority to provide this information and understand that I may be required to submit proof of this authority. My signature represents the signature of each dependent in accordance with permission he/she and/or the proper legal authority has previously permitted; (3) My plan benefits have been fully explained to me; (4) Information will be used and disclosed in accordance with state and federal laws and regulations for the sole purpose of treatment, payment or health care operations and adherence to other legal documents as applicable. Such laws and regulations may pertain to a dependent's individual right to privacy which may supersede those provided to me as subscriber, including consideration given to extended family members (e.g. step or non-biological children) or 12-17 year old minors; (5) On behalf of myself and my subscriber's, I hereby consent to the provision of care and treatment by GHC-SCW and its employees.

Signature of Applicant	Date
Signature of Spouse/Partner	Date
Signature of Dependent 18 Years of Age and Older	Date

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