Completing Employee Change Form

Use this form to make changes to a current employee's demographic information or coverage. Group Health Cooperative of South Central Wisconsin (GHC-SCW) requires the receipt of this application within 30 days after becoming eligible for GHC-SCW coverage. If the application is not submitted to GHC-SCW within this period of time, you may be considered a late entrant and subject to a waiting period of 12 months.

This application is a legal document, so it is important that you fill it out completely and correctly. An incomplete application will delay the application process and access to appointments and services. The following instructions will help you complete the form.

Section 1 – Employer Use Only
This section should be completed by the employer. Complete all the blank spaces in this section.

→ Choose the reason for the application

- Transfer to Cobra/Continuation
  - Complete Section 2 & 3 for any dependents electing coverage.
  - Sign form in Section 5
- Address Change
  - Complete Section 2 & 5 with new address information
- Terminate Coverage
  - Complete Section 2 & 5
- Change Plan
  - In Section 1 fill in new medical 4 digit plan number members is moving into
  - Complete Section 2 & 5
- Name Change
  - Complete Section 2 & 5 with new information
- Add Dependent(s)
  - Select reason for dependent eligibility in Section 1
  - Complete Sections 2,3,4 &5
- Drop Dependent(s)
  - Select reason for dependent being dropped from policy
  - List dependent(s) to be dropped from the policy in Section 1
  - Complete Section 2 & 5

The rest of the application should be filled out by the employee electing the coverage

Section 2 – Employee Information
Complete all blank spaces in this section with the employee/subscriber's information.

Section 3 – Covered Dependent Information
Complete all blank spaces f or eligible Cobra/Continuation dependents or for eligible dependents being added to the policy.

→ For additional dependents make a copy of this section of the application and attach.

Section 4 – Transition of Care
Fill in applicable information for any new dependent(s) being added to the policy in order to transition their care

Section 5 – Signature
Read the terms and conditions and sign and date the application.

Group Health Cooperative
of South Central Wisconsin

ADMINISTRATIVE USE ONLY	
Group Number	Effective Date

EMPLOYEE CHANGE FORM

SECTION ONE - EMPLOYER USE ONLY

Employer/Group Name	Employer/Group Number	Effective Date of Change

Reason: ☐ Transfer to Cobra/Continuation ☐ Address Change ☐ Name Change: List Previous Name _____

☐ Terminate Coverage: Reason _____ ☐ Change Plan: New Medical Plan Number _____ ☐ GHC Select ☐ HMO ☐ POS ☐ PPO

☐ Add Dependent(s) - ☐ Health Plan ☐ Dental Plan

(select one of the following) ○ Birth ○ Marriage: Date _____ ○ Domestic Partnership: Date _____

○ Adoption *(attach adoption paperwork)* ○ Loss of Coverage: Previous Carrier _____ Policy Number _____

○ Other: Explain _____

☐ Drop Dependent(s) - ☐ Health Plan ☐ Dental Plan

(select one of the following ○ Divorce: Date _____ ○ Other: Explain _____

Dependent _____ Date of Birth _____ GHC-SCW Member Number _____

Dependent _____ Date of Birth _____ GHC-SCW Member Number _____

Dependent _____ Date of Birth _____ GHC-SCW Member Number _____

Dependent _____ Date of Birth _____ GHC-SCW Member Number _____

Group Leader Name	Date	Phone	Email

SECTION TWO - EMPLOYEE INFORMATION

Last Name *(as listed on Social Security Card)*	First Name *(as listed on Social Security Card)*	M.I.	Date of Birth *(mm/dd/yyyy)*	Social Security # *(required)*

Mailing Address	City	State

Home Phone _____ Work Phone _____ Cell Phone _____	Marital Status ☐ Single ☐ Divorced ☐ Married ☐ Other ☐ Domestic Partnership	Gender ☐ Male ☐ Female	*Zip*	*County*
			Email Address *(providing email address authorizes GHC-SCW to use securely)*	

SECTION THREE - COVERED DEPENDENT INFORMATION (ONLY COMPLETE FOR DEPENDENT(S) BEING ADDED)

Last Name *(as listed on Social Security Card)*	First Name *(as listed on Social Security Card)*	M.I.	Previous Name	Relationship ☐Spouse/Partner ☐Child ☐Other:_____	Mailing Address if different than subscriber
Date of Birth *(mm/dd/yyyy)*	SSN# *(required)*	Gender ☐Male ☐Female	Tobacco Use* ☐Yes ☐No	PCP/Clinic Choice**	
				Email Address	

When enrolled in Group Health Cooperative of South Central Wisconsin (GHC-SCW), will this dependent be covered by any other health insurance? *(please do not list insurance being replaced by GHC-SCW)* ☐ Yes, complete the following information. ☐ No, skip to section four.

Health Insurance Name		Health Insurance Phone
Health Insurance Address	Name of Policyholder	Policyholder Date of Birth
Effective Date of Policy	Employer Name	Group Number and Patient ID Number

Is this dependent eligible for Medicare Coverage? ☐ Yes ☐ No

Reason ☐ESRD ☐Disabled ☐Over 65	Part A (Hosp.) Effective Date	Part B (Med.) Effective Date	Part D (Drug) Effective Date	Medicare Number

Last Name *(as listed on Social Security Card)*	First Name *(as listed on Social Security Card)*	M.I.	Previous Name	Relationship ☐Spouse/Partner ☐Child ☐Other:_____	Mailing Address if different than subscriber
Date of Birth *(mm/dd/yyyy)*	SSN# *(required)*	Gender ☐Male ☐Female	Tobacco Use* ☐Yes ☐No	PCP/Clinic Choice**	
				Email Address	

When enrolled in Group Health Cooperative of South Central Wisconsin (GHC-SCW), will this dependent be covered by any other health insurance? *(please do not list insurance being replaced by GHC-SCW)* ☐ Yes, complete the following information. ☐ No, skip to section four.

Health Insurance Name		Health Insurance Phone
Health Insurance Address	Name of Policyholder	Policyholder Date of Birth
Effective Date of Policy	Employer Name	Group Number and Patient ID Number

Is this dependent eligible for Medicare Coverage? ☐ Yes ☐ No

Reason ☐ESRD ☐Disabled ☐Over 65	Part A (Hosp.) Effective Date	Part B (Med.) Effective Date	Part D (Drug) Effective Date	Medicare Number

** Tobacco Use is defined as the use of tobacco product or products four or more times per week within no longer than the past 6 months by legal users of tobacco products (those 18 years of age and older) and includes all tobacco products.*

*** HMO & POS Members Only; if you do not select a PCP for yourself and/or your dependents, GHC-SCW will assign you and/or your dependents one*

SECTION FOUR - TRANSITION OF CARE (ONLY APPLICABLE IF ADDING A DEPENDENT(S))

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 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 - 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	DATE

MAIL: GROUP HEALTH COOPERATIVE OF SOUTH CENTRAL WISCONSIN, ATTN: ELIGIBILITY/MEMBERSHIP, P.O. BOX 44971, MADISON, WI 53744-4971

FAX: (608) 662-4837