Completing Group Employee Application

Use this application for employees that are electing coverage for the first time due to new group enrollment, new hire eligibility, or another qualifying trigger event.

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, or until your employer's next open enrollment period (if applicable).

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 blank spaces in this section.

- → No application will be processed without a date of hire
- → Use the 4 digit plan number in the Medical Plan Number box to identify the benefit plan the employee is electing
    - If dental benefits are available and the employee is electing dental coverage include the 3 digit dental plan number in the Dental Plan Number box
    - Only fill in the plan numbers for the benefits the employee is electing
- → If the qualifying event is loss of other coverage please include one of the following:
    - a Certificate of Creditable Coverage
    - a copy of the front and back of the employee's ID card from their previous carrier
    - list the previous carrier name, phone number and policy number

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 in this section for any dependents to be covered under this policy.

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

Section 4 – Other Coverage
Complete this section for anyone listed on the application that will be covered by any other health insurance or is Medicare eligible while enrolled in Group Health Cooperative of South Central Wisconsin.

Section 5 – Transition of Care
Fill in applicable information for any member(s) listed on the policy in order to transition your care

Section 6 – Optional Information
Complete this section for the subscriber of the policy.

Section 7 – Signature
Read the terms and conditions and sign and date the application.

Section 8 – Waiver
This section should only be completed if the employee is waiving coverage for themselves or any other eligible dependent.

Group Health Cooperative
of South Central Wisconsin

GROUP EMPLOYEE APPLICATION

ADMINISTRATIVE USE ONLY	
Group Number	Effective Date

SECTION ONE - EMPLOYER USE ONLY

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

Qualifying Event: ☐ New Employer Group ☐ New Hire ☐ Annual Dual Choice ☐ Other *(please include date of event)*: _____

☐ Loss of other coverage, list previous Carrier Name/Phone Number/Policy Number:

Part-Time Date of Hire	Full-Time Date of Hire	Hrs./Wk	☐ Management ☐ Non-Management ☐ Salary ☐ Hourly ☐ Union ☐ Non-Union	☐ GHC Select ☐ HMO ☐ POS ☐ PPO Medical Plan Number / Dental Plan 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	Zip	County

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

Tobacco Use* ☐ Yes ☐ No	Primary Care Provider (PCP)/Clinic Choice**:

SECTION THREE - COVERED DEPENDENT INFORMATION

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	PCP/Clinic Choice** Email Address	Tobacco Use* ☐ Yes ☐ No

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	PCP/Clinic Choice** Email Address	Tobacco Use* ☐ Yes ☐ No

** 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*

OVER TO CONTINUE SECTION THREE

SECTION THREE - COVERED DEPENDENT INFORMATION

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	PCP/Clinic Choice** / Email Address		Tobacco Use* ☐Yes ☐No
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	PCP/Clinic Choice** / Email Address		Tobacco Use* ☐Yes ☐No

SECTION FOUR - OTHER COVERAGE

When enrolled in Group Health Cooperative of South Central Wisconsin (GHC-SCW), will anyone listed on this application 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 five.

Health Insurance Name		Health Insurance Phone
Health Insurance Address	Name of Policyholder	Policyholder Date of Birth
Effective Date of 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 FIVE - 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 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 SIX - OPTIONAL INFORMATION

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 SEVEN - 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

SECTION EIGHT - WAIVER

I understand that I am eligible for group health insurance through my employer. I do NOT want, and hereby waive, group health insurance for: ☐ Waiving for myself

☐ Waiving for my spouse/domestic partner ☐ Waiving for my dependent child(ren) ☐ Waiving for me, my spouse/domestic partner and my dependent child(ren)

Reason for waiver:
☐ I (and/or my dependents) will be enrolled in a similar health plan through my employer ☐ Other
☐ I (and/or my dependents) will be covered by another health plan, which provides benefits that are similar to this plan.
☐ My earnings are such that I would have to pay more than 10% of my annualized gross income towards health insurance

I certify that I have been provided the opportunity to apply for GHC-SCW coverage. I decline to enroll on my behalf and that of my dependents. I understand that as a result of this wavier, my dependents and I will be subject to the following:

1. If I am declining coverage because of other health coverage, I may be able to enroll myself and/or my dependents when other coverage ends, provided that I do so within 30 days of my other coverage ending.
2. If I gain a new dependent as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and/or my dependents, provided that I do so within 30 days after the event.
3. If neither of the above applies, then I will be considered a late enrollee and will be subject to delayed effective date. For large employers, a late enrollee will be subject to a 12-month delayed effective date. For small employers, a late enrollee must wait until the employer's next open enrollment period to enroll. During this time, premiums will not be collected and benefits will not be provided to me (and/or my dependents).

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