2026 Individual Application

Columbia, Green and Sauk Counties

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

Group Health Cooperative of South Central Wisconsin

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.

Please choose one of the following plans for your 2026 Health Insurance Coverage

Plan Name	Plan Type (please only select one option)
Gold Plans	☐ Partners HMO Gold 4000 Ded/4000 MOOP HSA ☐ Partners HMO Gold 2000 Ded/8200 MOOP ☐ Partners HMO Gold 1500 Ded/8000 MOOP with Vision
Silver Plans	☐ Partners HMO Silver 5975 Ded/5975 MOOP HSA ☐ Partners HMO Silver 5500 Ded/8500 MOOP ☐ Partners HMO Silver 6000 Ded/8900 MOOP with Vision
Bronze Plans	☐ Partners HMO Bronze 7500 Ded/10000 MOOP HSA ☐ Partners HMO Bronze 10600 Ded/10600 MOOP HSA ☐ Partners HMO Bronze 6000 Ded/10600 MOOP HSA

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
- ☐ Name Change
- ☐ Dropping Dependent
- ☐ Address Change
- ☐ Termination of the Policy
- ☐ 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	

2026 Individual HMO Application

Columbia, Green and Sauk Counties

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

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SECTION ONE - Applicant Information

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

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

Full Legal Last Name	Full Legal First Name	M.I.	Previous Name	Relationship ☐ Spouse/Partner ☐ Child ☐ Other:	Mailing Address (if different than subscriber)
Date of Birth (mm/dd/yyyy)	Social Security # *(required)*	Legal Sex ☐ Male ☐ Female ☐ X	PCP/Primary 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 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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Group Health Cooperative of South Central Wisconsin (GHC-SCW)
MK22-137-3(8.25)F
*Affordable Care Act (ACA)

Group Health Cooperative of South Central Wisconsin

ghcscw.com

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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 (mm/dd/yyyy)
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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