2026 Individual Application

Columbia, Green 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.





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 |

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|--|------|--|--|
| | | | |

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

- o Address Change
- o Termination of the Policy
- o 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 · · · · · ·

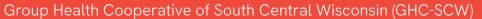
| GHC-SCW Administrative Information | | | | | | | |
|------------------------------------|------------------|--------------|--|--|--|--|--|
| Date Received | Effective Date | Group Number | | | | | |
| Contact Type | Transaction Type | | | | | | |
| Check Number | Check Amount | | | | | | |
| Agent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





2026 Individual HMO Application

Columbia, Green and Sauk Counties





| SECTION ONE - Applicant Information | | | | | | | | |
|--|---------------------------------|----------------------------------|---------------------|---|--|---------------------|---|---------------------------------------|
| Full Legal Last Name | Full Legal First Name | M.I. | Date of | Date of Birth (mm/dd/yyyy) | | So | Social Security # (required) | |
| Residential Address | | City | | State | State | | | County |
| Home Phone Marital Status Single Divol | | Legal Sex orced Male | | Email / | Email Address (providing email address authorizes GHC-SCW to | | | |
| Work Phone | | er | Female X | Previo | us Name | | | |
| Tobacco Use* Yes No | Primary Care Provider (PCP)/Pri | mary Clinic (| Choice** | | | | | |
| SECTION TWO - Covered Dep | endent Information | | | | | | | |
| Full Legal Last Name | Full Legal First Name | M.I. | Previo | Previous Name Relation Spous Child Other: | | Ship Mailing Addre | | ddress (if different than subscriber) |
| Date of Birth (mm/dd/yyyy) | Social Security # (required) | Legal Sex Male Female X | | PCP/Prir | nary Clini | Tobacco Use* Yes | | |
| | | | | Email Ac | ddress | No | | |
| Full Legal Last Name | Full Legal First Name | M.I. Pr | | us Name | Name Relationship Spouse/Partner Child Other: | | Mailing Address If different than subscriber) | |
| Date of Birth (mm/dd/yyyy) | Social Security # (required) | Legal Sex | | PCP/Prir | PCP/Primary Clinic Choice** | | | Tobacco Use* |
| | | F | Male Female X | | Email Address | | | No |
| Full Legal Last Name | Full Legal First Name | M.I. | M.I. Previous | | Name Relationship Spouse/Partner Child Other: | | Mailing Address # different than subscrib. | |
| Date of Birth (mm/dd/yyyy) | Social Security # (required) | Legal | | PCP/Prir | PCP/Primary Clinic Choice** | | | Tobacco Use* Yes |
| | | Male Female | | Email Ac | Email Address | | | No |
| | | X | | | | | | |

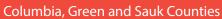
*Tobacco Use is defined as the use of tobacco product or products four or more times per week within no longer than the past six months by legal users of tobacco products (those 18 years of age and older) and includes all tobacco products.

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





2026 Individual HMO Application







| 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 | | | | alth Insurance Phon | ie | | |
| 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 Part A (Ho | sp.) Effective Date Part B (Me | d.) Effective Date | Part D (Drug) Effective Date Medicare Number | | | e Number | |
| SECTION FOUR - Transition of Care In order to | properly transition your care, please provid | e the following information fo | or all applying t | or coverage. | | | |
| Is anyone under the care of the following speci | alists? | | | | | | |
| Cardiologist Endocrinologist Nephrologist Neurologist Oncologist Rheumatologist Name of Individual Specialty Care Specialty Care Provider Full Name/City/State | | | | | matologist | | |
| | | | | | | | |
| | | | | | | | |
| Will anyone have prescriptions that will need r | efills? Yes. Please of | complete the followi | ing informa | ation below. | No | | |
| Name of Individual Na | me of Prescription | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| SECTION FIVE | | | | | | | |
| What is your language of choice? | | Are you Hispanic/ Yes | Latino? No | Decline to A | nswer | | |
| Please select category that best describes you | race - select all that apply. | | | | | | |
| American Indian or Alaska Native Asian | Black or African American | Native Hawaiiar | 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 O | der | | Date | | | | |



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