SecurityHealth Plan℠

Promises kept, plain and simple.®

1515 North Saint Joseph Avenue
P.O. Box 8000
Marshfield, WI 54449-8000

1.800.472.2363 | 715.221.9555
TTY 711 | Fax: 715.221.9974

Large and Small Employer (with medical questions)

Employee Health Insurance Application

A signature within Section F and/or G is required to make the application valid.
If you need additional space, use a separate sheet of paper and attach it to this application (sign and date the additional sheet).

FOR OFFICE USE ONLY

Group number _____

Effective date (m/d/y) _____ /_____ /_____

A. Employer information

Employer name

B. Employee information

Fill out the entire application and include information for spouse and/or dependents seeking coverage.

First name, middle initial and last name	Former last name (if applicable)	Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic partner

Sex assigned at birth ☐ Male ☐ Female	Social Security number	Date of birth (m/d/y)	Height	Weight

Physical address (P.O. box not accepted)	City	State	ZIP	County
Mailing address ☐ Same as physical address	City	State	ZIP	County

Home phone number (area code)	Work phone number (area code)	Cell phone number (area code)

Email address	Primary care provider/facility

Work status and qualifying election:

☐ Actively working: Hire/rehire date (m/d/y) _____ /_____ /_____
Date of change from part-time to full-time (m/d/y) _____ /_____ /_____ **OR** Return to work date (m/d/y) _____ /_____ /_____
☐ Retired date (m/d/y) _____ /_____ /_____

If you are enrolling due to a loss of coverage, submit proof of loss to your employer.

☐ COBRA or state continuation: Start date (m/d/y) _____ /_____ /_____ End date (m/d/y) _____ /_____ /_____
☐ Special enrollment *(qualifying event and event date required)* Date of event (m/d/y) _____ /_____ /_____
☐ Birth/adoption ☐ Marriage ☐ Permanent move ☐ Loss of coverage ☐ Individual coverage HRA

Race or ethnicity:

☐ White ☐ Black or African American ☐ Hispanic or Latino
☐ Asian ☐ Native American ☐ Alaska Native
☐ Native Hawaiian ☐ Pacific Islander
☐ Specify _____

What primary language is spoken in your home:

☐ English
☐ Specify _____

Coverage desired:

☐ Single ☐ Employee + spouse ☐ Employee + child(ren) ☐ Family

WAIVING COVERAGE ***(skip to Section G. Health coverage waiver)***

If married and only selecting coverage for yourself, complete Section G for your spouse/dependent.

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C. Dependent information *List everyone enrolling in coverage (spouse, dependents)*

Name *(First, MI, Last)*	Birth date *(m/d/y)*	*Sex assigned at birth*	Social Security number	Relationship	Primary care practitioner name and facility	Age 14 & over	
						Height	Weight
	__/__/__	☐ M ☐ F		☐ Spouse ☐ Domestic partner*			
	__/__/__	☐ M ☐ F		☐ Child/stepchild ☐ _____			
	__/__/__	☐ M ☐ F		☐ Child/stepchild ☐ _____			
	__/__/__	☐ M ☐ F		☐ Child/stepchild ☐ _____			
	__/__/__	☐ M ☐ F		☐ Child/stepchild ☐ _____			

* If allowed by your plan

Do any of the above family members live at a different address: ☐ Yes ☐ No

If yes, indicate name and address _____

D. Information regarding other health coverage and/or Medicare

1. **If you, your spouse or your dependent child(ren) listed in this application have current coverage that will continue after your Security Health Plan coverage starts, complete the following table or submit a copy of your insurance card.**

Subscriber of other health coverage and/or Medicare		DOB (m/d/y) _____ /_____ /_____
Insurance company	Group number	Policy number
Family members covered		**Type of coverage:** ☐ Employer group health coverage ☐ Drug coverage only ☐ Individual health coverage

2. **Are you or any of your family members eligible for Medicare:** ☐ Yes ☐ No

If yes, complete the following or attach a copy of your Medicare card.

Name of person covered by Medicare _____ Medicare card number _____

Is Medicare eligibility due to: ☐ Over age 65 ☐ End-stage renal disease (ESRD) ☐ Total disability

Effective dates (m/d/y): Part A __/__/__ Part B __/__/__ Part C (Medicare Advantage) __/__/__ Part D __/__/__

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E. Health information

Do not complete this section if you are enrolling as a new hire or late enrollee into an existing plan.

Note: You are required to forward to the insurer or third-party administrator any changes relative to dependents and/or in your or any dependent's health history that occur prior to your receipt of our written underwriting decisions on this application.

1. Does anyone named in this application take any prescribed medications: ☐ Yes ☐ No

   If yes, complete the following table:

Person's name	Drug name	Person's name	Drug name

2. Has anyone named in this application used tobacco or smokeless tobacco during the past six months: ☐ Yes ☐ No

   If yes, name of each person (we reserve the right to verify this information):

3. Has anyone named in this application ever been diagnosed with or treated for diabetes: ☐ Yes ☐ No

   If yes, person's name _____ ☐ Type 1 ☐ Type 2

   Date first diagnosed (m/d/y) _____ /_____ /_____ Date last treated (m/d/y) _____ /_____ /_____

4. Are you or any dependent now pregnant or an expectant parent: ☐ Yes ☐ No

   If yes, person's name _____ Relationship _____ Due date (m/d/y) _____ /_____ /_____

5. Has anyone named in this application ever been diagnosed with or treated for cancer: ☐ Yes ☐ No

   If yes, person's name _____ Location or type of cancer _____

   Describe treatment _____

   Date first diagnosed (m/d/y) _____ /_____ /_____ Date last treated (m/d/y) _____ /_____ /_____ ☐ No recurrence

   Date of any recurrence (m/d/y) _____ /_____ /_____ Describe _____

6. Has anyone named in this application ever been diagnosed with or treated for heart disease: ☐ Yes ☐ No

   If yes, person's name _____ Describe disease _____

   Describe treatment _____

   Date first diagnosed (m/d/y) _____ /_____ /_____ Date last treated (m/d/y) _____ /_____ /_____

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7. Within the past five years, has anyone named in this application (to be covered by this insurance) had:
   a. Any other injury, illness or treatment for any condition not already listed: ☐ Yes ☐ No
      If yes, person's name _____ Describe (include date) _____
   b. Been hospitalized or been scheduled for hospitalization: ☐ Yes ☐ No
      If yes, person's name _____ Describe (include date) _____
   c. Had any surgery or has surgery scheduled: ☐ Yes ☐ No
      If yes, person's name _____ Describe (include date) _____
   d. Had a test or has a test scheduled: ☐ Yes ☐ No
      If yes, person's name _____ Describe (include date) _____
   e. Been recommended to have a test or surgery which was not performed for any reason not already mentioned in this application (we are not seeking the results of HIV antibody test.): ☐ Yes ☐ No
      If yes, person's name _____ Describe (include date) _____

8. Has anyone named in this application, previously or presently, been considered for, on a list for or scheduled for a transplant: ☐ Yes ☐ No
   If yes, describe (include date) _____

F. Terms and conditions

- All statements and answers in this application are representations made by the applicant on his/her own behalf and for the other persons named in this application to induce the issuance of the contract(s) applied for.
- Subject to acceptance of this application by Security Health Plan of Wisconsin, Inc. it is understood and agreed that each participant consents to furnish Security Health Plan of Wisconsin, Inc. with all such medical and surgical reports, records and other information as requested to process claims. This might include signing a form for the release of information from hospitals, doctors and other health care providers to Security Health Plan of Wisconsin, Inc.
- Subject to the acceptance of this application by Security Health Plan of Wisconsin, Inc., the applicant authorizes the named group as his/her remitting agent to deduct from his/her wages or salary an amount equal to a) the existing subscription fees or b) the difference between the existing subscription fees and that contribution made by his/her employer.
- Any misrepresentation contained in this application and relied upon by the insurer may be used to reduce or deny a claim or void the contract within the contestable period if such misrepresentation materially affects the acceptance of risk. I also understand that if I decline any coverage, future changes in coverage are NOT automatic and may be subject to the insurer's approval. I further understand and acknowledge that any person with intent to defraud or knowledge of facilitating a fraud against an insurer, submits an application or files a claim using a false and/or deceptive statement is committing a crime.
- This form is an application for coverage only. Regardless of any advance payment of premiums, the policy applied for will become effective only upon the acceptance of this application by Security Health Plan of Wisconsin, Inc., to be evidenced by the issuance of an identification card and booklet/certificate.
- Security Health Plan of Wisconsin, Inc. may request proof of documentation related to an employee's enrollment eligibility. Employee agrees to cooperate in providing any such documentation requested.

I agree that the above answers are true and complete to the best of my knowledge and are made to induce the issuance of and as part of the policy I am applying for. I apply for enrollment subject to the terms and conditions above.

Applicant's signature (required) _____ **Date (m/d/y)** _____ /_____ /_____

If you are waiving coverage for ANYONE, make sure you sign page 5 of the application.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Complete this section if someone assisted you in the completion of this application.

The following person assisted me in completing the application _____

Explain your relationship with the applicant _____

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G. Health coverage waiver

I understand that if I decline coverage at this time for my spouse/domestic partner, my dependent children or myself and apply for coverage later, I/they may need to wait for coverage until an annual enrollment date.

1. I understand that I am eligible to apply for group health insurance through my employer. I do not want, and hereby waive, group health insurance for the following individuals: *(check [✓] all boxes that apply)*

☐ Myself ☐ Spouse ☐ Dependent child(ren), list names _____

2. I am waiving group health insurance because: *(check [✓] all boxes that apply)*

☐ I (and/or any dependents) will be covered by another health benefit plan.

Name of insurance company _____

☐ The annualized premium contribution to be paid by me on behalf of myself or my dependent spouse and/or child(ren) would exceed 10% of my annualized gross earnings from this employer (applicable for small employers only).

☐ Other reason _____

_____

Waiver:

I certify that I have been given the opportunity to apply for group health insurance and decline to enroll as indicated above, on behalf of myself, my spouse and/or my dependent child(ren). I understand that by signing this waiver, I, my spouse and/or my dependent child(ren) forfeit the right to coverage. I was not pressured, forced or unfairly induced by my employer, the agent or the insurer(s) into waiving or declining the group health insurance. If in the future I apply for coverage, I, my spouse or any of my dependent child(ren) 19 years and older may be treated as a late enrollee and subject to postponement.

I understand that if I am declining enrollment for myself, my spouse or my dependent child(ren) because of other health insurance, I may in the future be able to enroll myself, my spouse or my dependent child(ren) in this plan, provided I request enrollment within 31 days after my other health coverage ends. In addition, if I gain a dependent spouse or child(ren) as a result of marriage, birth, adoption or placement for adoption, I understand that I may be able to enroll myself, my spouse and/or my dependent child(ren), provided that I request enrollment within 31 days after the marriage, birth, adoption or placement for adoption. I understand that I can obtain enrollment information from my employer or group health insurance carrier.

Signature _____ **Date (m/d/y)** _____ /_____ /_____

If you are electing coverage for yourself, please make sure you sign page 4 of the application.

H. Nondiscrimination notice

Security Health Plan of Wisconsin, Inc., complies with applicable federal civil rights laws and does not discriminate, exclude or treat people differently on the basis of race, color, national origin, religion, pregnancy and related conditions, sex (including sexual orientation, gender identity, sex stereotypes, sex characteristics and intersex traits), age, disability, health status, marital status, arrest or conviction record or military participation in the administration of the plan, including enrollment and benefit determinations.

Limited English Proficiency Language Services

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-800-472-2363 (TTY 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-472-2363 (TTY 711).

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-472-2363 (TTY 711).

If you require materials in large print, call 1-800-472-2363 (TTY 711).

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