SecurityHealth Plan℠
Promises kept, plain and simple.®

1515 North Saint Joseph Avenue
PO Box 8000
Marshfield, WI 54449-8000

1.800.472.2363 | 715.221.9555
TTY: 711 | Fax: 715.221.9974

Large and Small Employer

Employee Health Insurance Application

A signature within Section 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

SMID # _____

Effective date _____ /_____ /_____

A. Employer information

Employer legal 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

Gender: ☐ Male ☐ Female | Social Security number | Date of birth *(m/d/y)*

Physical address *(PO 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

Work status and qualifying election:

☐ Actively working: Average weekly hours _____

Hire/Rehire date *(m/d/y)* _____ /_____ /_____ **OR** **Recall date** *(m/d/y)* _____ /_____ /_____

☐ Retired: Date *(m/d/y)* _____ /_____ /_____

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

☐ COBRA or state continuation: Start date *(m/d/y)* _____ /_____ /_____ End date *(m/d/y)* _____ /_____ /_____

☐ Special enrollment reason _____ Date of event *(m/d/y)* _____ /_____ /_____

Race or ethnicity:

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

What primary language is spoken in your home:

☐ English
☐ Specify _____

Coverage desired:

☐ Single ☐ EE + spouse
☐ EE + child(ren) ☐ Family
☐ Waive

If you waive coverage for yourself or any dependents, please complete Section H.

FOR OFFICE USE ONLY

Network *(large employer)*:
☐ Affirm ☐ Explore ☐ Premier
☐ Discover ☐ Inspire

Product type:
☐ HMO ☐ POS

Network *(small employer)*:
☐ Reliance (EPO)
☐ Tradition (HMO)
☐ Independence (POS)
☐ Freedom (Indemnity)

☐ HSA-qualified/ HDHP

Deductible _____ Group number _____

Location/Class/Sub-group _____

C. Applicant and dependent information

List all dependents, spouse and child(ren) enrolling in coverage.

	Name *(First, MI, Last)*	Birth Date *(m/d/y)*	Gender	Relationship	Primary Care Practitioner Name and Facility *(Strongly Recommended)*	Age 14 & Over*	
						Height	Weight
Applicant			☐ M ☐ F	☐ Applicant			
Spouse	Social Security number		☐ M ☐ F	☐ Spouse ☐ Domestic partner**			
Dependent	Social Security number		☐ M ☐ F	☐ Child/Stepchild ☐ Grandchild ☐ _____			
Dependent	Social Security number		☐ M ☐ F	☐ Child/Stepchild ☐ Grandchild ☐ _____			
Dependent	Social Security number		☐ M ☐ F	☐ Child/Stepchild ☐ Grandchild ☐ _____			
Dependent	Social Security number		☐ M ☐ F	☐ Child/Stepchild ☐ Grandchild ☐ _____			

* Applicable only to large employer applicants if more than 50 employees
** If allowed by your plan

D. Additional health coverage information

Complete this section only if you are an employee newly joining your employer's health plan or an employee with a special enrollment period.

1. **Does the dependent child(ren) named within this application live with you at the address shown above:** ☐ Yes ☐ No

   If no, list the dependent child(ren)'s name and address(es) _____

   _____

2. **Is there a stipulation in a legal decree or court order stating who is responsible for providing health insurance of the named dependent child(ren):** ☐ Yes ☐ No

   If yes, attach a copy of the legal decree or court order.

   Name of the person who has primary custody of the dependent child(ren) _____

   Name of the person responsible for health insurance _____

E. Medicare/Other insurance information

1. **Are you, your spouse or your child(ren) currently enrolled in Medicare:**

☐ Yes – *Complete question #1 for each person enrolled in Medicare*

☐ No – *Proceed to question #2 in this section*

- Name _____ Medicare claim no. _____

Medicare Part A: ☐ Yes ☐ No
Medicare Part B: ☐ Yes ☐ No
Medicare Part C: ☐ Yes ☐ No
Medicare Part D: ☐ Yes ☐ No

Reason for Medicare: ☐ Over age 65 ☐ Disability ☐ End-stage renal disease (ESRD)

Medicare Part A effective date *(m/d/y)* _____/_____/_____
Medicare Part B effective date *(m/d/y)* _____/_____/_____

Medicare Part C (Medicare Advantage) effective date *(m/d/y)* _____/_____/_____
Medicare Part D effective date *(m/d/y)* _____/_____/_____

- Name _____ Medicare claim no. _____

Medicare Part A: ☐ Yes ☐ No
Medicare Part B: ☐ Yes ☐ No
Medicare Part C: ☐ Yes ☐ No
Medicare Part D: ☐ Yes ☐ No

Reason for Medicare: ☐ Over age 65 ☐ Disability ☐ End-stage renal disease (ESRD)

Medicare Part A effective date *(m/d/y)* _____/_____/_____
Medicare Part B effective date *(m/d/y)* _____/_____/_____

Medicare Part C (Medicare Advantage) effective date *(m/d/y)* _____/_____/_____
Medicare Part D effective date *(m/d/y)* _____/_____/_____

Your information collected in question #2 will help the employer's insurer(s) to coordinate benefits with any other group health coverage you may continue after this coverage is in effect. You are not reducing the group health insurance for which you are applying by providing this information.

2. **Do you, your spouse or your dependent child(ren) listed in this application have current coverage that will continue after your SHP coverage starts:** ☐ Yes ☐ No

If yes, complete the following table. Starting with you, the employee, identify each person applying for insurance and include information for all current health insurance coverage(s).

Name	Insurance Company, Plan and Group Number	Effective Date of Coverage *(m/d/y)*	Type of Coverage *(See Key Below)*
		___ / ___ / ___	
		___ / ___ / ___	
		___ / ___ / ___	

Type of coverage key: G = group comprehensive major medical; M = Medicare supplement; D = drug coverage only; I = individual comprehensive major medical; H = hospital coverage only; V = vision coverage only

F. Health information

Applicable only to new large employer groups with more than 50 employees.
Do not complete this section if you are enrolling into an existing plan as a new hire or under a qualifying event.

Please ensure that you provided complete and thorough health data below. As an employee of a group that is new to Security Health Plan, this information is important in understanding potential health risks and identifying care management and wellness needs for employees.

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 6 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 high blood pressure (BP): ☐ Yes ☐ No

   If yes, person's name _____ Most recent BP reading _____

6. 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 _____

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

   Date of any recurrence *(m/d/y)* _____ /_____ /_____ ☐ No recurrence

7. 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)* _____ /_____ /_____

8. Within the past 5 years, has anyone named in this application (to be covered by this insurance) had:
   - any other injury, illness or treatment for any condition not already listed: ☐ Yes ☐ No
   - been hospitalized or been scheduled for hospitalization: ☐ Yes ☐ No
   - had any surgery or has surgery scheduled: ☐ Yes ☐ No
   - had a test or has a test scheduled: ☐ Yes ☐ No
   - 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, describe injury or illness and type of treatment *(include dates)* _____

   _____

   Describe tests, treatment, surgery or transplant that hasn't occurred yet *(include dates)* _____

   _____

G. 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.
- Subject to acceptance of this application by Security Health Plan of Wisconsin, Inc., the applicant agrees to use the services of Security Health Plan participating clinics, hospitals and physicians, except for "out-of-area emergency care" or when referred to a non-participating physician, clinic or facility. Written referrals must be arranged through a participating physician and approved by the Health Plan Medical Director prior to the receipt of services. These requirements do not apply to members enrolled in an Indemnity coverage option.
- 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.

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)***

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 _____

H. 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/Domestic partner ☐ Dependent children

Name(s) of individuals waiving coverage _____

_____

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 _____

☐ I will be enrolled in another health benefit plan offered by my employer.

Name of insurance company _____

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

☐ Other reason (provide written reason for waiving coverage) _____

_____

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 that 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)* _____ /_____ /_____

I. Nondiscrimination notice

Security Health Plan of Wisconsin, Inc., complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status.

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).

Return form by email at shpmember@securityhealth.org or fax to 715-221-9974.