Health Insurance Application/Change

Wisconsin Department
of Employee Trust Funds
PO Box 7931
Madison WI 53707-7931

1-877-533-5020 (toll free)
Fax 608-267-4549
etf.wi.gov

Please complete the requested information (signature required on Page 4) and ***return to your employer***. Retirees and continuants, return this form to the Department of Employee Trust Funds. Only the subscriber applying for coverage should complete this form. For eligibility and online enrollment information, see the It's Your Choice Web pages at etf.wi.gov. To elect the opt-out incentive if declining health insurance, complete Applicant Information and see Section 14. You must indicate whether you want dental coverage (Section 7) as part of your insurance, for an additional cost.

1. Applicant Information

Information on this page required unless otherwise stated.

Name *First*	*M.I.*	*Last*	Member ID	SSN

Former/Maiden (if applicable)	Telephone ( )	Email *(not required)*

Mailing address (Street)	City	State	ZIP code	Country

Birth date	Gender ☐ Male ☐ Female	Physician/Clinic

Check here if your name, phone, address, email or marital status has changed: ☐

Check your marital or domestic partnership status: Marital status change date: _______________

☐ Single *(no change date required)* ☐ Married ☐ Domestic partnership ☐ Divorced ☐ Widowed

Please check which applies to you (this determines your eligibility)

☐ Employee ☐ Non-WRS graduate assistant ☐ Retiree/LTDI ☐ COBRA recipient ☐ Surviving dependent

2. Spouse or Domestic Partner Information

Name *First*	*M.I.*	*Last*	*Former/Maiden*	SSN

Birth date	Gender ☐ Male ☐ Female	Physician/clinic

Check here if your spouse's or domestic partner's name has changed: ☐

Is your spouse/domestic partner a tax dependent? ☐ Yes ☐ No

3. Dependent Information (does not include spouse/domestic partner)

☐ Check to *only update* dependent information

Name *You may attach additional pages if more space is needed*			**SSN**	**Birth date**	**Gender** (M/F)	**Relationship** (child, stepchild, child of domestic partner, legal ward, dependent of minor dependent)	**Disabled** (Y/N)	**Tax dep?** (Y/N)	**Physician/ Clinic**
First	*M.I.*	*Last*							

Name: ______________________________________ Member ID: _______________

4. Complete if you are a New Hire Selecting or Declining Health Insurance Coverage

New hires or employees returning from leave (lapsed coverage) *only*: When do you want your coverage to be effective?

- ☐ When my employer contributes to my premium
- ☐ As soon as possible (you will pay the entire monthly premium until you are eligible for your employer contribution)
- ☐ I choose to decline/waive coverage *(to decline health insurance & elect the opt-out incentive, go to section 14)*
- ☐ I choose to decline/waive coverage ***because I have other health insurance coverage***

5. Complete if you are Not a New Hire Enrolling or Making a Change

Reason for Application: Select a reason for enrolling or changing your coverage or health plan:

- ☐ It's Your Choice open enrollment
- ☐ Eligible move to a new service area *(may only change health plan)*
- ☐ Eligible life event change (select change below)

Event date for move or life event change: ________________

Eligible life event changes, which allow you to make a change outside of the annual It's Your Choice open enrollment, include birth/adoption, marriage/domestic partnership and divorce. Visit etf.wi.gov for a *Life Change Event Guide*.

Select the event that allows you to enroll or make a change outside of your initial hire period. You may be required to provide supporting documentation (the ***** indicates that you must provide proof of the selected event). See more information on Page 6. *If adding dependents, please list them in Section 3. If removing, list them, in Section 8.*

☐ **Change Health Plan** New health plan selected (*full health plan name required*): ________________________________

Select one reason to add coverage/dependent or remove dependent(s):

Add coverage/dependent(s)

- ☐ Marriage/Domestic partnership change*
- ☐ Transfer to a new state agency (state only)
  Former agency name: ___________________________
- ☐ Birth or adoption*
- ☐ LTE new hire (state only)
- ☐ COBRA (*Continuation-Conversion Notice* (ET-2311) also required)
- ☐ National Medical Support Notice*
- ☐ Spouse to spouse transfer
- ☐ Loss of employer contributions or loss of other coverage*
- ☐ State retiree re-enroll*
- ☐ Paternity acknowledgment*
- ☐ Legal ward/guardianship*
- ☐ Disabled, age 26+*
- ☐ Eligible dependent not on initial enrollment (excludes domestic partner/adult dependents)
- ☐ Other: ___________________

Remove dependent(s)

- ☐ It's Your Choice open enrollment
- ☐ Divorce/Domestic partnership terminated*
- ☐ Death of dependent
- ☐ Legal ward/guardianship end*
- ☐ Disabled dependent disability end or support/mainenance less than 50%
- ☐ Grandchild's parent age 18
- ☐ Adult dependent eligible for other coverage*
- ☐ Other: ___________________

Event date: ________________ (the * indicates that you must provide proof of the selected event)

6. Complete to Elect Your Health Insurance Coverage

Single or family coverage?	Are you selecting an HDHP?	Health plan selected (*full health plan name required*)
☐ Single ☐ Family	☐ Yes ☐ No	

State employees: Most state employees are eligible for a High Deductible Health Plan (HDHP). You must indicate if you choose HDHP. If you elect HDHP, you must also enroll in a state-sponsored health savings account (HSA).

Local Wisconsin Public Employer (WPE) employees: You may only choose a High Deductible Health Plan (HDHP) if your employer offers it. Check with your employer (or ETF for retirees/continuants) if you are not sure.

7. Complete if you are Enrolling in or Declining Dental Coverage

State employees: Indicate whether you are choosing Uniform Dental Benefits.

Local WPE employees: You may only choose Uniform Dental Benefits if your employer offers it. Check with your employer (or ETF for retirees/continuants) if you are not sure.

Do you want dental coverage? ☐ Yes ☐ No

You may only choose dental if you are also enrolling, or are already enrolled in, health insurance.

Note: If you are not currently enrolled in dental and do not want dental coverage for the next plan year, you do not need to decline dental coverage again.

If you are *not* a new hire and *only* wish to decline dental (and make no other changes to your health insurance) you do not need to complete the remainder of this form. You must sign in Section 15.

8. Complete if you are Removing a Spouse/Domestic Partner or Dependent(s)

Include address, if different than your address on Page 1

Name of person(s) you are removing *(first, m.i., last)*	Birth date	Address of person(s) you are removing

9. Complete if you are Changing from Family to Single Coverage

If your employee monthly premium share is pre-tax, IRC Section 125 restricts midyear changes to your coverage. (All retirees and continuants are post-tax.) For more information on IRC Section 125 limitations, visit www.irs.gov

My employee-required monthly premium contribution is deducted (*check one*):

- ☐ Pre-tax and my employee premium contribution has increased significantly
- ☐ Pre-tax eligible status change event – Change event: ____________________
- ☐ Pre-tax change to single during annual It's Your Choice (January 1)
- ☐ Post-tax (midyear changes to coverage level can be made at any time) – Event date: _____________

10. Complete if you are Cancelling Health Insurance Coverage

If your premiums are deducted on a post-tax basis (all retirees and continuants are post-tax), you may cancel coverage at any time. If they are deducted on a pre-tax basis, you must provide the event allowing midyear cancellation.

Please select your reason for cancelling coverage:

My premiums are deducted: ☐ Pre-tax (select an event below) ☐ Post-tax (no event required to cancel coverage)

- ☐ It's Your Choice open enrollment
- ☐ Retiree sick leave depleted – Effective end date of coverage: _____________
- ☐ I am terminating employment
- ☐ I am going on an unpaid leave of absence
- ☐ My employee premium share has increased significantly
- ☐ I and all eligible dependents are now eligible for, and enrolled in, other coverage* – Event date: _____________
  (the * indicates that you must provide proof of the selected event)
- ☐ Spouse/domestic partner to spouse/domestic partner transfer – Event date: _____________

11. Complete if you are Covered by Medicare

Are you, or any person you insure, covered by Medicare? ☐ Yes ☐ No

If yes, please check why you are eligible for Medicare: ☐ Age ☐ Disabillity ☐ End stage renal disease

Note: State employees are not eligible for HDHP if they have other coverage.

List all persons covered by Medicare, including yourself, Medicare claim number and Medicare Parts A and B effective dates:

Name (*first, m.i., last*)	**Medicare claim number**	**Medicare Part A effective date**	**Medicare Part B effective date**

12. Complete if you Have Additional Health Insurance/Coverage

Note: State employees are *not* eligible for HDHP if they have other coverage.

Do you or any of your dependents have other medical or health care Flexible Spending Account coverage that has a balance available as of the effective date of this coverage? (excludes dental or vision) ☐ Yes ☐ No

If yes, provide:

Company	Policy number	Group number

Name(s) of insured (*first, m.i., last*)

13. Complete if you Listed Dependent(s) on Page 1

Is any dependent listed on Page 1 your, or your spouse/domestic partner's, grandchild? ☐ Yes ☐ No
If yes, name of parent: ______________________________

14. Complete to Decline Health Insurance and Elect the Opt-Out Incentive

State of Wisconsin active employees only

Are you electing to receive the opt-out incentive for 2017? ☐ Yes ☐ No

If yes, you certify that you are eligible for the opt-out stipend and are not currently, nor will be this program year, a covered dependent under the State Group Health Insurance Program, and that you did not decline or waive coverage in 2015.

15. Signature *Required*

By signing this application, I apply for the insurance under the indicated health insurance contract made available to me through the state of Wisconsin and I have read and agreed to the *Terms and Conditions* (see Page 5). A copy of this application is considered as valid as the original. In addition, to the best of my knowledge, all statements and answers in this application are complete and true. Providing false information is punishable under Wis. Stat. § 943.395. Additional documentation may be required by ETF at any time to verify eligibility.

Signature	Date signed

Submit completed form to your employer. (Retirees and continuants, submit to ETF.)

Employer Completes

Employers: Coding instructions are in the *Employer Health Insurance Administration Manual*.

EIN	Employer name	Payroll representative email

Group number	Employee type	Coverage type ☐ Single ☐ Family	Health plan name/suffix

Business Unit *(if applicable)*	Employment status of applicant ☐ Full time ☐ Part time ☐ LTE	Employee deductions ☐ Pre-tax ☐ Post-tax

Hire date or date WRS-eligible employment or graduate appointment began	Employer received date	Event date	Prospective coverage date

Are you a WRS-participating employer? ☐ Yes ☐ No
Previous service check completed? ☐ Yes ☐ No
Source of previous service check? ☐ Online Network for Employers (ONE) ☐ ETF
Did employee participate in the WRS prior to being hired by you? ☐ Yes ☐ No

Payroll representative signature	Phone number	Date signed
	( )	

Terms and Conditions

To the best of my knowledge, all statements and answers in this application are complete and true. I understand that if I provide false or fraudulent information, misrepresentation or fail to provide complete or timely information on this application, I may face action, including, but not limited to, loss of coverage, employment action, and/or criminal charges/sanctions under Wis. Stat. § 943.395.

I authorize the Department of Employee Trust Funds to obtain any information from any source necessary to administer this insurance.

I agree to pay in advance the current premium for this insurance, and I authorize my employer (the remitting agent) to deduct from my wages or salary an amount sufficient to provide for regular premium payments that are not otherwise contributed. The remitting agent shall send the premium on my behalf to ETF.

I understand that eligibility for benefits may be conditioned upon my willingness to provide written authorization permitting my health plan and/or ETF to obtain medical records from health care providers who have treated me or any dependent(s). If medical records are needed, my health plan and/or ETF will provide me with an authorization form. I agree to respond to questions from health plans and ETF, including, but not limited to, audits, in a timely manner.

I have reviewed and understand the eligibility criteria for dependents under this coverage and affirm that all listed dependents are eligible. I understand that children may be covered through the end of the month they turn 26. Children may also be covered beyond age 26 if they: have a disability of long standing duration, are dependent on me or the other parent for at least 50% of support and maintenance, and are incapable of self-support; or are full-time students and were called to federal active duty when they were under the age of 27 years and while they were attending, on a full-time basis, an institution of higher education.

I understand that if my insured domestic partner and/or dependent child(ren) of my insured domestic partner are not considered "tax dependents" under federal law, my income will include the fair market value of the health insurance benefits provided to my domestic partner and/or domestic partner's dependent child(ren). Furthermore, I understand this may affect my taxable income and increase my tax liability.

I understand that it is my responsibility to notify the employer, or if I am a retiree or continuant to notify ETF, if there is a change affecting my coverage, including but not limited to, a change in eligibility due to divorce, marriage or domestic partnership, a change in the "tax dependent" status of my domestic partner and/or domestic partner's dependent children, or an address change due to a residential move. Furthermore, failure to provide timely notice may result in loss of coverage, delay in payment of claims, loss of continuation rights and/or liability for claims paid in error. Upon request, I agree to provide any documentation that ETF deems necessary to substantiate my eligibility or that of my dependent(s).

I understand that if there is a qualifying event in which a qualified beneficiary (me or any dependent(s)) ceases to be covered under this program, the beneficiary(ies) may elect to continue group coverage as permitted by state or federal law for a maximum of 18, 29, or 36 months, depending on the type of qualifying event, from the date of the qualifying event or the date of the notice from my employer, whichever is later. I also understand that if continuation coverage is elected by the affected qualified beneficiary(ies) and there is a second qualifying event (i.e, loss of eligibility for coverage due to death, divorce, marriage but not including non-payment of premium) or a change in disability status as determined by the Social Security Administration, continuation coverage, if elected subsequent to the second qualifying event, will not extend beyond the maximum of the initial months of continuation coverage. I understand that timely notification of these qualifying events must be made to ETF.

I understand that if I am declining enrollment for myself or my dependent(s) (including spouse or domestic partner) because of other health insurance coverage, I may be able to enroll myself and my dependent(s) in this plan if I or my dependent(s) lose eligibility for that other coverage (or if the employer stops contributing toward that other coverage). However, I must request enrollment within 30 days after my or my dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if I have (a) new dependent(s) as a result of marriage, domestic partnership, birth, acknowledgement of paternity, adoption, or placement for adoption, I may be able to enroll myself and my dependent(s) if I request enrollment within 30 days after the marriage or effective date of the domestic partnership, or within 60 days after the birth, acknowledgement of paternity, adoption, or placement for adoption. To request special enrollment or obtain more information, I should contact my employer (or ETF if I am a retiree or continuant).

I understand that I am responsible for enrolling in Medicare Parts A and B when I am first eligible and required by this coverage, and that as the subscriber I am responsible for ensuring my spouse, domestic partner and any other eligible dependents also enroll in Medicare Parts A and B when they are first eligible, to ensure proper coordination of benefits with Medicare. In the event I or any eligible dependent does not enroll in Medicare Parts A and B when first eligible and required by this group health insurance program, I understand that I will be financially liable for the portion of claims Medicare would have paid had proper Medicare enrollment been attained.

I agree to abide by the terms of my benefit plan, as explained in any written materials I receive from ETF or my health plan, including, without limitation, the It's Your Choice materials.

Documentation Requirements

Reason for Change or Enrollment	Type of Documentation
*Adoption	Recorded copy of court order granting adoption or letter of placement for adoption.
* Cancel coverage/remove adult dependent due to enrollment in other health insurance coverage when premium contributions are deducted per-tax	Copy of medical ID card or letter from health plan indicating effective date of other coverage. Must be received within 30 days of enrollment in other coverage. Does not apply to retirees or post-tax deductions.
*Creating a domestic partnership	Copy of *Domestic Partner Affidavit Acknowledgement Letter* (ET-2373) indicating effective date of domestic partnership submitted to employer by employee. Health application adding domestic partner should be submitted to employer when *Affidavit of Domestic Partnership* (ET-2371) submitted to ETF.
*Death	Original death certificate.
*Disabled, age 26+	Copy of letter from health plan approving disabled status
*Divorce (Family coverage remains in place when more dependents than spouse/stepchildren covered.)	Copy of *Continuation-Conversion Notice* (ET-2311) sent to ex-spouse of the subscriber (ETF may request copy of divorce decree from clerk of courts showing date of entry of divorce if needed per the Terms and Conditions.)
*Eligible **and** enrolled in Medicare	Copy of Medicare card and *Medicare Eligibility Statement* (ET-4307). (**Note**: If you are on COBRA Continuation and the subscriber or dependents become Medicare eligible after the COBRA effective date, subscriber or dependent is no longer eligible to continue on COBRA.)
*Ending a domestic partnership	*Affidavit of Termination of Domestic Partnership* (ET-2372). (ETF may request copy of marriage certificate if marriage is reason for termination of domestic partnership per the Terms and Conditions.)
*Family to single because all dependents enrolled in other coverage	Copy of medical ID card or letter from health plan indicating effective date of other coverage. Must be received within 30 days of enrollment in other coverage. Does not apply to retirees or post-tax deductions.
*Legal change of name (other than due to marriage or divorce)	Copy of court order.
*Legal ward	Court Order (Letters of Guardianship) granting **permanent** guardianship of person.
*Loss of other coverage or loss of employer contribution to premiums (applies to member and dependents)	The following items on letterhead from the previous insurer or former employer, dated and issued after termination of coverage. Materials providing prospective termination dates are not acceptable. 1. Who was covered (must list the name of the member who is requesting this special, late enrollment) 2. Name of Health Insurer 3. Subscriber number and name 4. Date coverage was terminated 5. Reason for the cancellation (that is voluntary such as due to non-payment of premium vs. involuntary such as due to job loss). COBRA notice is acceptable if the coverage end date, covered individuals and health plan are indicated. If loss of employer premium contributions, letter from employer indicating they no longer contribute towards their employee's premium.
*National Medical Support Notice	Copy of National Medical Support Notice.
*Paternity	Court order declaring paternity, Voluntary Paternity Acknowledgement filed with DHS or birth certificate.
*Social Security number change	Copy of card or letter from Social Security Administration.
*State retiree re-enroll	Same as loss of other coverage and a *Sick Leave Re-enrollment Application* (ET-4317). During It's Your Choice, no documentation required.
Birth	Original birth certificate not required. (ETF may request documentation per the Terms and Conditions.)
Change of address/telephone	No documents required but ETF may request per the Terms and Conditions.
Divorce (family to single)	No documents required but ETF may request per the Terms and Conditions.
Marriage	Original marriage certificate is not required. (ETF may request per the Terms and Conditions.)

*Documentation required/must be submitted to ETF.

Discrimination is Against the Law 45 C.F.R. § 92.8(b)(1) & (d)(1)

The Department of Employee Trust Funds complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. ETF does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

ETF provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats. ETF provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact ETF's Compliance Officer, who serves as ETF's Civil Rights Coordinator.

If you believe that ETF has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Compliance Officer, Department of Employee Trust Funds, 801 West Badger Road, P.O. Box 7931, Madison, WI 53707-7931; 1-877-533-5020; TTY: 1-800-947-3529; Fax: 608-267-4549; Email: ETFSMBPrivacyOfficer@etf.wi.gov. If you need help filing a grievance, ETF's Compliance Officer is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201; 1-800-368-1019; TDD: 1-800-537-7697. Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-533-5020 (TTY: 1-800-833-7813).

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-877-533-5020 (TTY: 1-800-947-3529).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-533-5020（TTY：1-800-947-3529）

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-533-5020 (TTY: 1-800-947-3529).

ملاحظة: إذا كنت تتحدث اللغة العربية، فهناك خدمة مساعدة متاحة بلغتك دون أي مصاريف: اتصل بالرقم 1-877-533-5020 (خدمة الصم والبكم: 1-800-947-3529)

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-533-5020 (телетайп: 1-800-947-3529).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-533-5020 (TTY: 1-800-947-3529)번으로 전화해 주십시오.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-533-5020 (TTY: 1-800-947-3529).

Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-877-533-5020 (TTY: 1-800-947-3529).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-877-533-5020 (TTY: 1-800-947-3529).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-533-5020 (ATS : 1-800-947-3529).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-533-5020 (TTY: 1-800-947-3529).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-877-533-5020 (TTY: 1-800-947-3529) पर कॉल करें।

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-877-533-5020 (TTY: 1-800-947-3529).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-533-5020 (TTY: 1-800-947-3529).