SecurityHealth Plan[SM]

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

FOR OFFICE USE ONLY

SMID # ______________ Effective date ____ /____ /____

Election:

☐ $__________________ ☐ $__________________
☐ $__________________ ☐ $__________________

Large Business

Employee Health Insurance Application

A signature on page 5 is required to make the application valid.

Employer information

Employer name	Group number	Location/Class

Employee information *(print using black or blue ink – fill out the entire application for each person for whom coverage is being sought)*

First name, middle initial and last name | Former last name (if applicable) | Gender: ☐ Male ☐ Female | Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally separated

Social Security number ___ ___ ___ – ___ ___ – ___ ___ ___ ___ | Date of birth *(mm/dd/yyyy)* ___ ___ / ___ ___ / ___ ___ ___ ___ | Height: ______ ft. _____ in. | Weight: ____________ lbs.

Residence – street address | City | State | ZIP | County

Mailing – street address ☐ Same as residence | City | State | ZIP | County

Home phone number *(area code)* (___ ___ ___) ___ ___ ___ – ___ ___ ___ ___ | Work phone number *(area code)* (___ ___ ___) ___ ___ ___ – ___ ___ ___ ___ | Cell phone number *(area code)* (___ ___ ___) ___ ___ ___ – ___ ___ ___ ___

Email address | Primary care provider name (first and last) | Facility/Clinic location primary care is received from

Work status:

☐ Actively working: Hire date ________________ OR recall date ________________ ☐ Retired: Date _____________

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

☐ COBRA or state continuation: Start date ________________ End date ________________ ☐ Special enrollment period: Date _____________

Coverage desired:

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

If you are choosing to waive coverage for yourself or for any of your dependents, please proceed to the "health coverage waiver" section on page 3.

Service area: ☐ Central ☐ Valley

Product type: ☐ HMO ☐ POS ☐ Indemnity ☐ Open Access

Plan option ____

Deductible ______________ Coinsurance _______________ Copay: ☐ Yes ☐ No

☐ HSA-qualified/HDHP

Dependent information

List all dependents, spouse and child(ren) applying for insurance. If you need additional space, use a separate sheet of paper and attach it to this application *(sign and date the additional sheet)*.

Name *(First, MI, Last)*	**Gender**	**Social Security Number**	**Relationship**	**Birth Date** *(MM/DD/YY)*	*(Age 14 and over only)* **Height**	**Weight**
	☐ Male ☐ Female	__ __ __ – __ __ – __ __ __ __	☐ Spouse ☐ Domestic partner	__ __ / __ __ / __ __		
Primary care provider name *(first, last)*			Facility health care is received from			
	☐ Male ☐ Female	__ __ __ – __ __ – __ __ __ __	☐ Child ☐ Stepchild ☐ Grandchild ☐ _______________	__ __ / __ __ / __ __		
Primary care provider name*(first, last)*			Facility health care is received from			

 © 2017 Security Health Plan of Wisconsin, Inc.

Dependent information *(continued)*

Name *(First, MI, Last)*	**Gender**	**Social Security Number**	**Relationship**	**Birth Date** *(MM/DD/YY)*	*(Age 14 and over only)* **Height**	**Weight**
	☐ Male ☐ Female	___ ___ ___ – ___ ___ – ___ ___ ___ ___	☐ Child ☐ Stepchild ☐ Grandchild ☐ __________	___ ___ / ___ ___ / ___ ___		
Primary care provider name *(first, last)*			Facility health care is received from			
	☐ Male ☐ Female	___ ___ ___ – ___ ___ – ___ ___ ___ ___	☐ Child ☐ Stepchild ☐ Grandchild ☐ __________	___ ___ / ___ ___ / ___ ___		
Primary care provider name *(first, last)*			Facility health care is received from			
	☐ Male ☐ Female	___ ___ ___ – ___ ___ – ___ ___ ___ ___	☐ Child ☐ Stepchild ☐ Grandchild ☐ __________	___ ___ / ___ ___ / ___ ___		
Primary care provider name *(first, last)*			Facility health care is received from			
	☐ Male ☐ Female	___ ___ ___ – ___ ___ – ___ ___ ___ ___	☐ Child ☐ Stepchild ☐ Grandchild ☐ __________	___ ___ / ___ ___ / ___ ___		
Primary care provider name *(first, last)*			Facility health care is received from			

Additional health coverage information

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) ______________________________

____

If there is a stipulation in a legal decree or court order stating who is responsible for providing health insurance of the named dependent child(ren):

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

Name of the person responsible for health insurance ______________________________

Is anyone named in this application currently enrolled in Medicare:

☐ Yes, complete below ☐ No, go on to page 3

If you need to complete this section for more than one person, use a separate sheet of paper and attach it to this application (sign and date the additional sheet).

Are you, your spouse or your child(ren) covered by

Medicare Part A: ☐ Yes ☐ No

Medicare Part B: ☐ Yes ☐ No

Medicare Part C: ☐ Yes ☐ No

Medicare Part D: ☐ Yes ☐ No

If yes, name of person covered by Medicare ______________________________

Medicare claim no. ______________________

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

Medicare Part A effective date ___ ___ / ___ ___ / ___ ___

Medicare Part B effective date ___ ___ / ___ ___ / ___ ___

Medicare Part C (Medicare Advantage) effective date ___ ___ / ___ ___ / ___ ___

Medicare Part D effective date ___ ___ / ___ ___ / ___ ___

 © 2017 Security Health Plan of Wisconsin, Inc.

Additional health coverage information *(continued)*

Your information 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.

Do you, your spouse or your dependent child(ren) listed in this application have current health insurance coverage: ☐ 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 *(MM/DD/YY)*	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

Health coverage waiver

I understand that if I decline coverage at this time and apply for coverage at a later date, I may need to wait for coverage until an annual enrollment date.

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 *(mark all boxes that apply)*:

☐ Myself ☐ Spouse ☐ Dependent children

I am waiving group health insurance because *(mark 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 (month/day/year) _______ /_______ /_______

 © 2017 Security Health Plan of Wisconsin, Inc.

Health information

Make certain you answer all of the questions on this application completely and thoroughly. Do not include genetic testing results in your responses. If you need additional space, use a separate sheet of paper and attach it to this application. (Sign and date the additional sheet.)

Does anyone named in this application take any prescribed medications:

☐ Yes, complete the following table

Person's Name	Drug Name

☐ No

Has anyone named in this application used tobacco or smokeless tobacco during the past 6 months:

☐ Yes, name of each person*

*We reserve the right to verify this information.

☐ No

Has anyone named in this application ever been diagnosed with or treated for diabetes:

☐ Yes, person's name ____________________________

☐ Type 1 ☐ Type 2

Date first diagnosed ____________________________

Date last treated ______________________________

☐ No

Are you or any dependent now pregnant or an expectant parent:

☐ Yes, person's name ____________________________

Relationship _______________ Due date __________

☐ No

Has anyone named in this application ever been diagnosed with or treated for high blood pressure:

☐ Yes, person's name ____________________________

List the last three blood pressure readings

____

____

____

☐ No

Has anyone named in this application ever been diagnosed with or treated for cancer:

☐ Yes, person's name ____________________________

Location or type of cancer ______________________

Date first diagnosed ____________________________

Date last treated ______________________________

Date of any recurrence _________ ☐ No recurrence

☐ No

Has anyone named in this application ever been diagnosed with or treated for heart disease:

☐ Yes, person's name ____________________________

Describe disease ______________________________

Describe treatment ____________________________

Date first diagnosed ____________________________

Date last treated ______________________________

☐ No

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; been hospitalized or been scheduled for hospitalization; had any surgery or has surgery scheduled; had a test or has a test scheduled; or 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, describe injury or illness and type of treatment (include dates) ______________________________

____

____

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

____

☐ No

 © 2017 Security Health Plan of Wisconsin, Inc

Optional information

To better assist you, please complete the following optional information. Your answers will not affect your enrollment.

		Subscriber	Spouse	Dependent Name ______	Dependent Name ______	Dependent Name ______
Language	What is your preferred spoken language?	☐ English ☐ Specify______	☐ English ☐ Specify______	☐ English ☐ Specify______	☐ English ☐ Specify______	☐ English ☐ Specify______
	What is your preferred written language?	☐ English ☐ Specify______	☐ English ☐ Specify______	☐ English ☐ Specify______	☐ English ☐ Specify______	☐ English ☐ Specify______
Race/Ethnicity	What race are you?	☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or other Pacific Islander ☐ Specify______ ☐ Two or more races	☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or other Pacific Islander ☐ Specify______ ☐ Two or more races	☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or other Pacific Islander ☐ Specify______ ☐ Two or more races	☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or other Pacific Islander ☐ Specify______ ☐ Two or more races	☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or other Pacific Islander ☐ Specify______ ☐ Two or more races
	What is your ethnic background?	☐ Hispanic/Latino ☐ Not Hispanic/Latino	☐ Hispanic/Latino ☐ Not Hispanic/Latino	☐ Hispanic/Latino ☐ Not Hispanic/Latino	☐ Hispanic/Latino ☐ Not Hispanic/Latino	☐ Hispanic/Latino ☐ Not Hispanic/Latino

Terms and conditions

1. 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.
2. 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.
3. 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.
4. 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.
5. 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 below.

____ ______ /______ /______
Applicant's signature ***(required)*** Date (month/day/year)

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 ______________________________

 © 2017 Security Health Plan of Wisconsin, Inc.

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, age, disability or sex.

Limited English proficiency services

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).

 © 2017 Security Health Plan of Wisconsin, Inc.