

Medical
Wisconsin Physicians
Service Insurance
Corporation
Policy Number
163776

Dental
Delta Dental

Policy Number
91408

Vision
AIG Life Insurance Co

Number
18187

Life/AD&D/STD/LTD/Dependent Life
The Lincoln National Life Insurance
Company

Policy Number
10080000 (Life and AD&D)
10080002 (LTD)
10080001 (STD)

EMPLOYEE ENROLLMENT FORM

Wisconsin Bankers Association Insurance Trust

Please complete this form if you are enrolling in a coverage you do not currently have.

Please Print EMPLOYER please complete the shaded area			Requested Effective Date:		Annual Salary \$ _____	
Billing # 2016 _____	Medical Section #	Dental Section #	Dept. #	Employer Contact		
Employer Name			City		Employer Phone ()	

A. EMPLOYEE INFORMATION						
Last Name		First Name		Initial	Social Security Number	
Street Address				City	State	Zip
Home Phone	<input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth	<input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widow(er)		
Date First Worked: Full Time ___/___/___ Part Time ___/___/___		# Scheduled Hours Per Week _____	Are you actively at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	Status:	<input type="checkbox"/> Active <input type="checkbox"/> Rehire <input type="checkbox"/> Retiree <input type="checkbox"/> Return from leave <input type="checkbox"/> COBRA Date:	
Job Title:						

B. DEPENDENT INFORMATION: COMPLETE FOR ALL DEPENDENTS WHO ARE APPLYING FOR COVERAGE						
Last Name		First Name		Initial	Sex	Birth Date
Spouse						Full-Time Student
						SSN# _____ - _____ - _____
DEPENDENTS						<input type="checkbox"/> Yes <input type="checkbox"/> No SSN# _____ - _____ - _____
						<input type="checkbox"/> Yes <input type="checkbox"/> No SSN# _____ - _____ - _____
						<input type="checkbox"/> Yes <input type="checkbox"/> No SSN# _____ - _____ - _____
						<input type="checkbox"/> Yes <input type="checkbox"/> No SSN# _____ - _____ - _____
Do all people covered under this insurance reside at the same location? <input type="checkbox"/> Yes <input type="checkbox"/> No						
If no, please indicate the individual's name, the city in which they live and phone number.						

C. CHECK THE TYPES OF COVERAGES YOU ARE APPLYING FOR						
MEDICAL:	<input type="checkbox"/> Employee Only	<input type="checkbox"/> Employee & Children	<input type="checkbox"/> Employee & Spouse	<input type="checkbox"/> Employee, Spouse, & Children		
DENTAL:	<input type="checkbox"/> Employee Only	<input type="checkbox"/> Employee & Children	<input type="checkbox"/> Employee & Spouse	<input type="checkbox"/> Employee, Spouse, & Children		
VISION:	<input type="checkbox"/> Employee Only	<input type="checkbox"/> Employee & Children	<input type="checkbox"/> Employee & Spouse	<input type="checkbox"/> Employee, Spouse, & Children		
Enroll	<input type="checkbox"/> Life & AD&D	<input type="checkbox"/> Dep. Life	<input type="checkbox"/> STD	<input type="checkbox"/> LTD		
Beneficiary						
Last Name		First		Initial	Relationship	% to each

D. ENROLLMENT STATUS

I am applying as a

New Hire

(You must apply during your probationary period)

Late Applicant

Late medical applicants are normally subject to a pre-existing condition limitation period. Vision and dental plans do not allow for enrollment as a late applicant. Late applicants for Life and AD&D, Dependent Life, Long and Short Term Disability are subject to Evidence of Insurability. Please refer to the terms and conditions in the benefit booklet or check with your employer.

Special Enrollment Period (Some plans do not allow for a special enrollment period, please check with your employer.)

Birth

Adoption

Marriage

Termination or exhaustion of coverage (i.e. divorce, death of spouse)

Other (Please explain) _____

Important Notice: Your medical plan may include a pre-existing condition limitation period. This period may be offset by time covered under a qualified medical plan. Please attach a Certificate of Coverage to verify your time served under a qualified medical plan.

E. COMPLETE THE FOLLOWING IF YOU ARE APPLYING FOR MEDICAL COVERAGE.

Will the coverage you are applying for replace a health insurance policy currently in force or a health insurance policy that has terminated within the past 63 days?	<input type="checkbox"/> Yes ⇒ <input type="checkbox"/> No	Please complete the information in this section and attach coverage certification. Without this certificate, you may be subject to a pre-existing condition limitation period. You have a right to request a certificate of creditable coverage from your prior plan. If necessary, WPS will assist you in obtaining a certificate from the prior plan.
---	--	---

Policyholder's Name	Social Security Number	<input type="checkbox"/> Single Plan <input type="checkbox"/> Family Plan	Effective Date	Termination Date
Name of Insurance Company	City	State	Policy I.D. Number	Group Number

Were all dependents covered under this prior policy? Yes No (If No, Provide Details)

F. COMPLETE IF YOU HAVE OTHER INSURANCE, ARE MEDICARE ELIGIBLE OR HAVE EXISTING WPS COVERAGE.

1) Does anyone named in this application have other group insurance coverage, or have existing WPS coverage?	<input type="checkbox"/> Yes (Complete 1a-i, 2 & 3) <input type="checkbox"/> No (Complete 2 & 3)	1a) Type of Coverage <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
1b) Individual's Employer	Employer Phone	
1c) Name under which policy is listed	1d) Social Security Number	1e) <input type="checkbox"/> Single Plan <input type="checkbox"/> Family Plan
1g) Name of Insurance Company, City (mailing address for claims), State, Phone Number	1h) Policy I.D. No.	1i) Group No.

2) Do you or your spouse have dependent children from a previous marriage? Yes No

3) Is anyone named in this application eligible for Medicare coverage? Yes No

Name of Person

3a) Reason Over 65 Disabled

3b) Medicare Card No.

3c) Part A (Hosp.) Effective Date

3d) Part B (Med.) Effective Date

G. TERMS AND CONDITIONS

1. The availability of any coverage to the Applicant and/or spouse is determined by the Employer's inclusion of that coverage in the Group's plan of insurance. The coverages, if so included, are provided by the following companies: Wisconsin Physicians Service Insurance Corporation ("WPS"), AIG Life Insurance Company; Delta Dental; and The Lincoln National Life Insurance Company. Such companies shall hereinafter be referred to as "Insurer(s)".
2. All statements are true and complete and answers in this form are representations made by the Applicant on behalf of himself/herself and the dependents, if any, named herein to induce the issuance of the contract(s) applied for. The contents of this form are to be solely relied upon by the Insurer(s) exclusive of the knowledge of an agent or employee of the Insurer(s).
3. The Applicant and/or spouse on behalf of himself/herself and the dependents, if any, named herein, agrees to cooperate in providing the Insurer(s) with information needed to process this form. This might include signing a form for the release by hospitals, doctors and other health care providers of pertinent health care records to the Medical Information Bureau, the Insurer(s) or their legal representatives.
4. No person except an officer of the Insurer(s) is authorized to vary or modify a contract.
5. Subject to the acceptance of this Application by the Insurer(s), the Applicant authorizes the Employer to deduct from the Applicant's wage or salary his/her portion, if any, of the premium for the coverages applied for and to timely remit such portion to the party designated by the Insurer(s).
6. Coverage is in effect only after: (a) the Insurer(s) approve this enrollment form, and (b) I complete any probationary period required by my Employer.
7. The contract(s) applied for will become effective only upon the Applicant's completion of the probationary period, if any, and acceptance of this Application by the Insurer(s)/Company(ies). The Insurer(s)/Company(ies) will notify the Applicant of his/her effective date and issue an identification card for medical, dental and vision coverages.
8. This Application, when approved, and any endorsement, amendment or rider hereto will be made part of the contract(s) applied for.

NOTICE: A PERSON MAY BE COMMITTING INSURANCE FRAUD, IF HE OR SHE SUBMITS AN APPLICATION OR CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT WITH INTENT TO DEFRAUD (OR KNOWING THAT HE OR SHE IS HELPING TO DEFRAUD) AN INSURANCE COMPANY.

SIGNATURE	Please print name here: _____	
	<input checked="" type="checkbox"/>	
	Signature of Applicant	Date Signed

Employer Should Review Completed Form and Send to:



Wisconsin Bankers Association Insurance
Trust
P.O. Box 7697
Madison, WI 53707-7697
Telephone: 1-888-441-0600