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 #	Billing Unit #	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	Email Address

❑ Male ❑ Female	Date of Birth	❑ Single ❑ Divorced ❑ Married ❑ Widow(er)

Date First Worked: Full Time ____/____/____ Part Time ____/____/____ Job Title:	# Scheduled Hours Per Week	Are you actively at work? ❑ Yes ❑ No	Status: ❑ Active ❑ Rehire ❑ Retiree ❑ Return from leave ❑ COBRA Date:

B. DEPENDENT INFORMATION: COMPLETE FOR ALL DEPENDENTS WHO ARE APPLYING FOR COVERAGE

	Last Name First Name Initial	Sex	Birth Date	Full-Time Student?	Social Security Number
Spouse			__ __-__ __-__ __		SSN# __ __ __ - __ __ - __ __ __ __
DEPENDENTS			__ __-__ __-__ __	❑ Yes ❑ No	SSN# __ __ __ - __ __ - __ __ __ __
			__ __-__ __-__ __	❑ Yes ❑ No	SSN# __ __ __ - __ __ - __ __ __ __
			__ __-__ __-__ __	❑ Yes ❑ No	SSN# __ __ __ - __ __ - __ __ __ __
			__ __-__ __-__ __	❑ Yes ❑ No	SSN# __ __ __ - __ __ - __ __ __ __
			__ __-__ __-__ __	❑ Yes ❑ No	SSN# __ __ __ - __ __ - __ __ __ __

Do all people covered under this insurance reside at the same location? ❑ Yes ❑ No

If no, please indicate the individual's name, the city in which they live and phone number.

Name_____ City _____ Phone number _____

Name_____ City _____ Phone number _____

C. CHECK THE TYPES OF COVERAGES YOU ARE APPLYING FOR

MEDICAL:	❑ Employee Only	❑ Employee & Children	❑ Employee & Spouse	❑ Employee, Spouse, & Children
DENTAL:	❑ Employee Only	❑ Employee & Children	❑ Employee & Spouse	❑ Employee, Spouse, & Children
VISION:	❑ Employee Only	❑ Employee & Children	❑ Employee & Spouse	❑ Employee, Spouse, & Children

Enroll	❑ Group Term Life & AD&D	❑ Dependent Life	❑ STD	❑ LTD	❑ Voluntary Life, Employee – Coverage Requested: $ _____ ❑ Voluntary Life, Spouse – Coverage Requested: $ _____ ❑ Voluntary Life, Dependent – Coverage Requested: $ 10,000

Beneficiary Information for Life Product(s)

Last Name	First	Initial	Relationship to Insured	Birth Date	Primary or Contingent?	% 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. Late dental applicants are subject to benefit restrictions. Vision 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 plan 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): _____

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

1)	Does anyone named in this application have other group insurance coverage, or have existing UHC or WPS coverage?	❑ Yes (Complete 1a-i, 2 & 3) ❑ No (Complete 2 & 3)	1a) Type of Coverage ❑ Medical ❑ Dental ❑ Vision
	1b) Individual's Employer	Employer Phone	
	1c) Name under which policy is listed	1d) Social Security Number	1e) ❑ Single Plan ❑ Family Plan 1f) Effective Date
	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	

F. 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: United HealthCare Services, Inc. (UHC), Wisconsin Physicians Service Insurance Corporation (WPS), Delta Dental, National Vision Administrators, L.L.C. (NVA), Superior Vision, 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: _____
	_____ Signature of Applicant _____ Date Signed