Department of Employee Trust Funds
801 W. Badger Road
PO Box 7931
Madison, WI 53707-7931
1-877-533-5020 (toll-free)
Fax: 608-267-4549
etf.wi.gov

Health Insurance Application/Change Form

- Please complete the requested information and return to your employer (or ETF for Retirees/Continuants) as soon as possible. Only complete if you are the employee/retiree/continuant applying for coverage.
- Read the Terms and Conditions accompanying this application **prior** to signing and submitting to your employer (or ETF for Retirees/Continuants).
- HDHP is a High Deductible Health Plan as explained in the Information pages under Section 4.
- If available through your employer, you must indicate whether you wish to have Dental coverage as part of your insurance for an added cost.
- For detailed information regarding eligibility requirements, please read the informational pages attached.
- For information on required documentation (🖹), please see the included chart "Documentation Requirements" on Page 10.
- Go to etf.wi.gov for an online presentation to assist with this application.
- Contact your employer (or ETF for Retirees/Continuants) with any questions not answered here.

***Indicates required field** **IYC = Annual It's Your Choice**

I am electing to opt out of health insurance for 2016. ☐ Yes ☐ No

By checking **yes**, I certify that I am eligible for the opt-out stipend and am not currently, nor will I be this program year, a covered dependent under the State Group Health Insurance Program and that I did not opt out for program year 2015.

1. APPLICANT INFORMATION Please print | ETF Member ID* | SSN*

Eligibility reason: I am a/an:* ☐ Employee ☐ Graduate assistant ☐ Retiree/LTDI ☐ COBRA recipient ☐ Surviving dependent

First name*	M.I.	Last name*	Previous name

Home mailing address*—street and No.	City*	State*	ZIP code*	☐ Check here if updating address, name, phone, email or marital status.

Primary phone No.* ( )	Country (if not USA)	Applicant e-mail

Birth date*	Gender* ☐ M ☐ F	Physician/Clinic*

Marital or domestic partnership (DP) status* ☐ Single ☐ Married ☐ DP ☐ Divorced ☐ Widowed

Event Date* _____(not required for single)

2. SPOUSE/DOMESTIC PARTNER (DP) INFORMATION ☐ Check here if *only updating* spouse/DP information | SSN*

Name* (First, M.I., Last)	Previous name	Birth date*

Physician/Clinic*	Tax dependent ☐ Yes ☐ No	Gender* ☐ M ☐ F

3. DEPENDENT INFORMATION: (Excludes spouse/DP) Add Coverage, Add Dependent, Remove Dependent

☐ Check here if *only updating* dependent information

Social Security number*	First name*	M.I.	Last name*	Birth date*	Gender*	Rel. code*	Tax dep?	Disabled?	Enter Clinic/Physician* or Provide Dependent Address for COBRA, if removing (may attach separate sheet).

Complete Sections 1 and 2 of the application. Complete Section 3 if adding or removing dependents.

MID_____ SSN_____

4.ENROLLMENT INFORMATION

New Hire or Return from Leave and Coverage has Lapsed—I want my coverage to be effective:

- ☐ When employer contributes to premiums
- ☐ As soon as possible (employee will pay entire monthly premium until eligible for employer contribution)
- ☐ I Decline/Waive Coverage
- ☐ I Decline coverage ***because*** I have other coverage

Coverage desired*	Are you selecting an HDHP health plan?	Do you want dental coverage?	Health plan selected* (enter plan name)
☐ Single ☐ Family	☐ Yes ☐ No	☐ Yes ☐ No	

State employees must indicate whether they are choosing Uniform Dental Benefits. Most are also eligible for an HDHP and must indicate if they choose HDHP.

WPE employees may only choose Uniform Dental Benefits and/or the HDHP if their employer chose to offer these.

5.REASON FOR APPLICATION*

Please select the event that allows you to enroll outside of initial hire. Reasons marked with 🖹 require supporting documentation. See Page 10 for required documentation listing. **IYC = Annual It's Your Choice**

Add Coverage

- ☐ Spouse/DP to spouse/DP transfer
- ☐ Transfer from one employer to another employer
  Previous Employer*_____
- ☐ HIPAA (birth, adoption🖹, marriage, DP🖹, divorce🖹)
- ☐ LTE new hire (state only)
- ☐ Loss of Other Coverage/Employer Contributions🖹
- ☐ IYC (eff. Jan. 1)
- ☐ COBRA (ET-2311 required)
- ☐ **State retiree re-enroll**🖹

Effective date* _____

Add dependent

- ☐ HIPAA (birth, adoption🖹, marriage, DP🖹, divorce🖹)
- ☐ National medical support notice🖹
- ☐ Paternity acknowledgment🖹
- ☐ Legal ward/guardianship🖹
- ☐ Eligible dependent not on initial enrollment (excludes DP and adult dependents)
- ☐ Loss of other coverage/ employer contributions🖹
- ☐ Disabled, age 26+🖹
- ☐ IYC (eff. Jan. 1)

Remove dependent

- ☐ Divorce🖹/DP terminated🖹
- ☐ Death of dependent
- ☐ Legal ward/guardianship ends🖹
- ☐ Disabled dependent: Disability ends or support and maintenance less than 50%.
- ☐ Grandchild's parent turns age 18
- ☐ Adult dependent eligible for other coverage
- ☐ IYC (eff. Jan 1)
- ☐ Other _____

If adding or removing dependents, please list them in Section 3.

If removing dependents, list their address in Section 3 if it is different from your own.

Event date* _____

Complete the Coverage Desired, HDHP Selection, Dental Selection, and Health plan desired for 2016.

Change Health Plan (Check one box below, indicate current health plan, provide date of event, update Section 1, if applicable.)

Status Change events may include birth, adoption, marriage, creation of DP, divorce or termination of DP.

☐ Move from service area ☐ Eligible Status Change🖹 ☐ Annual IYC (Jan.1)

Status Change event*: _____

Current health plan*_____ Event date*_____

Family to Single Coverage: If your employee premium share is taken pre-tax, IRC Section 125 restricts midyear changes to your coverage.

My employee-required premium contribution is deducted: (Check one box, list event date and update Section 1.)

- ☐ Pre-tax and my employee premium contribution has increased significantly🖹
- ☐ Pre-tax eligible Status Change event🖹 : Event _____
- ☐ Pre-tax change to single during annual It's Your Choice (Jan. 1)
- ☐ Post-tax (midyear changes to coverage level can be made at any time)

Event date*_____

For more information on IRC Section 125 limitations, see the Information Pages Section 5 attached to this application

MID_____ SSN_____

Cancel Coverage – If your premiums are deducted on a post-tax basis, you may cancel coverage at any time. If they are deducted on a pre-tax basis, you must provide the event allowing midyear cancellation. *If transfering family coverage to your spouse/DP, please indicate the IRC Section 125 Status Change Event below.*

☐ Retiree sick leave depleted—effective end date of coverage _____

My Premiums are Deducted: ☐ Pre-tax (select an event below) ☐ Post-tax (no event required)

☐ I am terminating employment
☐ I am going on unpaid leave of absence
☐ My employee premium share has increased significantly
☐ Annual It's Your Choice Enrollment (Jan. 1)
☐ I and all eligible dependents became eligible for and enrolled in other coverage
☐ Spouse/DP to Spouse/DP Transfer

Event Date* _____

Additional Information* Is any dependent listed under Section 3 your or your spouse/DP's grandchild?

☐ No ☐ Yes If yes, name of parent_____

Medicare Information/Update Medicare Information* Are you or any person you insure, covered by Medicare?
☐ No ☐ Yes
If yes, list the eligibility reason, names of insured and Medicare Parts A and B **effective** dates.
Medicare eligible reason: ☐ Age ☐ Disabled ☐ End stage renal disease

Sign and Date in Section 6

Other Health Insurance Coverage/Update* (State employees are ineligible for HDHP if they have other coverage.)
D…have other medical or health care Flexible Spending Account coverage that has a…ve date of this coverage? (excludes dental or vision)
☐ …following:
N… _____ Policy No. _____ Group No. _____

Employer completes Section 7

Name(s) of Insured: _____

6.SIGNATURE* (Read the **Terms and Conditions** on Page 4 and sign and date the application.)
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**. 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.

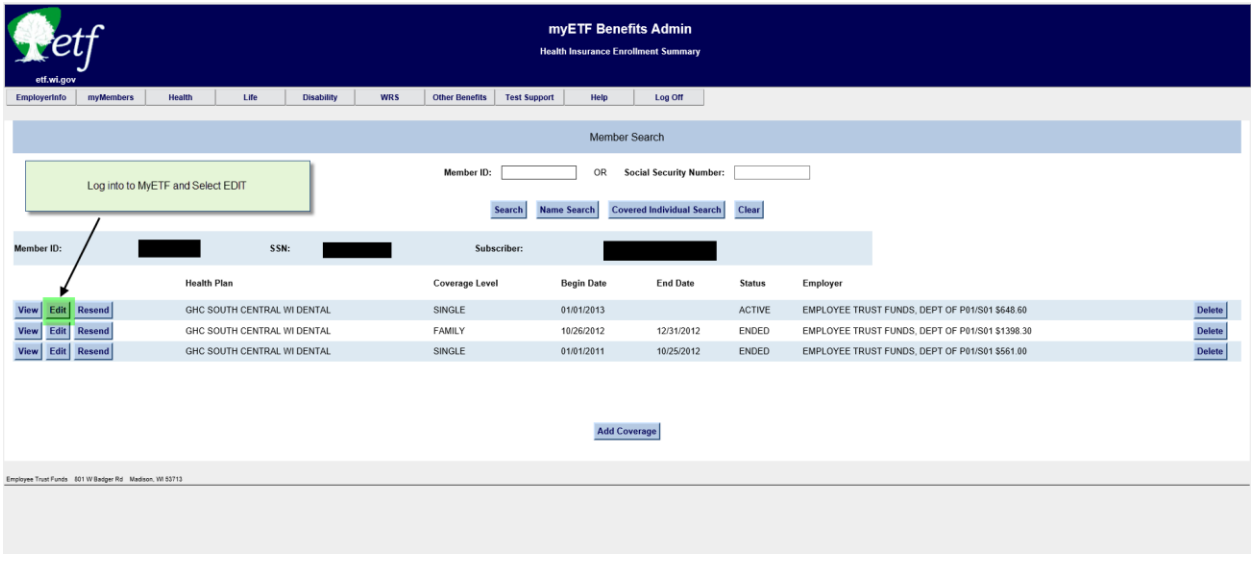
Sign and date Here & return to employer (ETF for Retirees/Continuants) _____ **Date Signed (mm/dd/yy)** _____

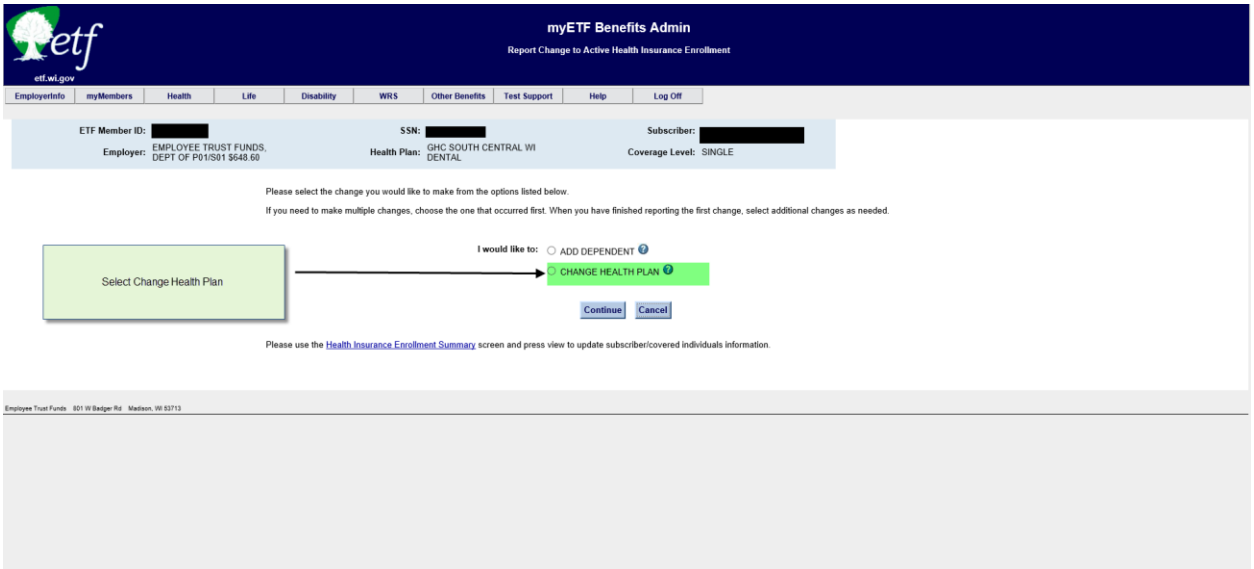
7.EMPLOYER COMPLETES (Coding instructions are in the Employer Health Insurance Administration Manual.)

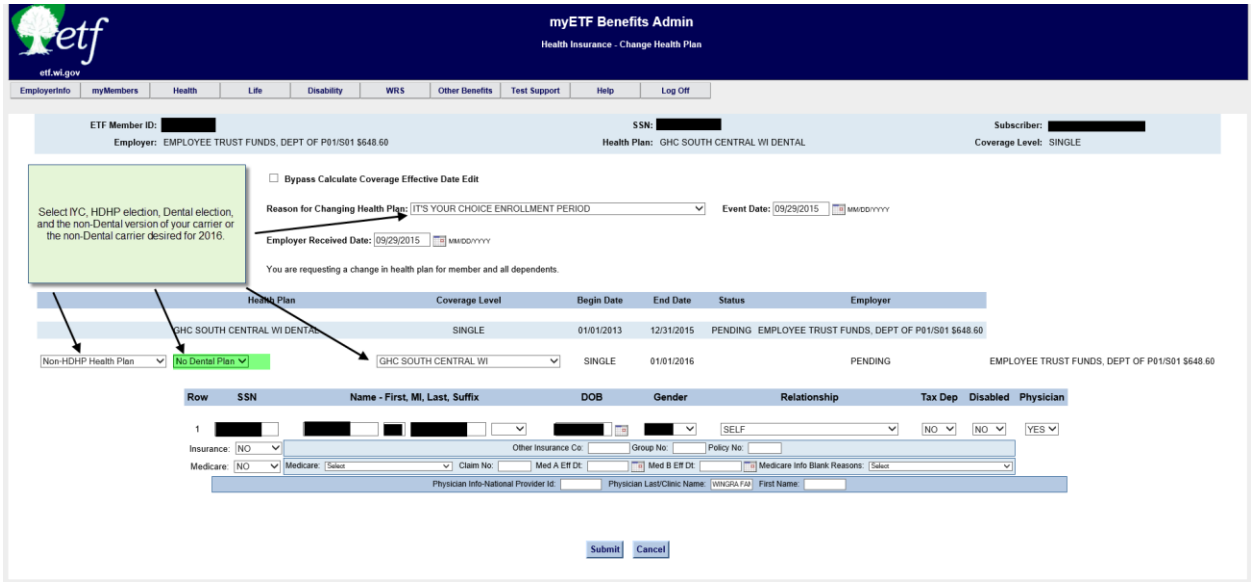
EIN 69-036-	Employer name		Payroll representative e-mail
Group number	Employee type	Coverage Type ☐ Single ☐ Family	Health plan name/suffix
Employment status: ☐ Full time ☐ Part time ☐ LTE		Employee deductions: ☐ Pre-tax ☐ Post-tax	

Previous service – complete information
1. Are you a WRS participating employer? ☐ Yes ☐ No *(If yes, answer remaining questions)*
2. Previous service check completed? ☐ Yes ☐ No
3. Did employee participate in the WRS prior to being hired by you? ☐ Yes ☐ No
4. Source of previous service check? ☐ Online Network for Employers (ONE) ☐ ETF

Date WRS eligible employment or graduate appointment began or hire date	Employer received date	Event date	Prospective coverage date
Payroll representative signature			Phone number ( )


myETF Benefits Admin
Health Insurance Enrollment Summary
etf.wi.gov
EmployerInfo
myMembers
Health
Life
Disability
WRS
Other Benefits
Test Support
Help
Log Off
Member Search
Log into to MyETF and Select EDIT
Member ID:
OR
Social Security Number:
Search
Name Search
Covered Individual Search
Clear
Member ID:
SSN:
Subscriber:
Health Plan
Coverage Level
Begin Date
End Date
Status
Employer
View Edit Resend GHC SOUTH CENTRAL WI DENTAL SINGLE 01/01/2013 ACTIVE EMPLOYEE TRUST FUNDS, DEPT OF P01/S01 $648.60 Delete
View Edit Resend GHC SOUTH CENTRAL WI DENTAL FAMILY 10/26/2012 12/31/2012 ENDED EMPLOYEE TRUST FUNDS, DEPT OF P01/S01 $1398.30 Delete
View Edit Resend GHC SOUTH CENTRAL WI DENTAL SINGLE 01/01/2011 10/25/2012 ENDED EMPLOYEE TRUST FUNDS, DEPT OF P01/S01 $561.00 Delete
Add Coverage
Employee Trust Funds 801 W Badger Rd Madison, WI 53713


myETF Benefits Admin
Report Change to Active Health Insurance Enrollment
etf.wi.gov
EmployerInfo
myMembers
Health
Life
Disability
WRS
Other Benefits
Test Support
Help
Log Off
ETF Member ID:
SSN:
Subscriber:
Employer: EMPLOYEE TRUST FUNDS, DEPT OF P01/S01 $648.60
Health Plan: GHC SOUTH CENTRAL WI DENTAL
Coverage Level: SINGLE
Please select the change you would like to make from the options listed below.
If you need to make multiple changes, choose the one that occurred first. When you have finished reporting the first change, select additional changes as needed.
Select Change Health Plan
I would like to:
ADD DEPENDENT
CHANGE HEALTH PLAN
Continue
Cancel
Please use the Health Insurance Enrollment Summary screen and press view to update subscriber/covered individuals information.
Employee Trust Funds 801 W Badger Rd Madison, WI 53713


etf
etf.wi.gov
myETF Benefits Admin
Health Insurance - Change Health Plan
EmployerInfo
myMembers
Health
Life
Disability
WRS
Other Benefits
Test Support
Help
Log Off
ETF Member ID: [redacted]
SSN: [redacted]
Subscriber: [redacted]
Employer: EMPLOYEE TRUST FUNDS, DEPT OF P01/S01 $648.60
Health Plan: GHC SOUTH CENTRAL WI DENTAL
Coverage Level: SINGLE
Select IYC, HDHP election, Dental election, and the non-Dental version of your carrier or the non-Dental carrier desired for 2016.
Bypass Calculate Coverage Effective Date Edit
Reason for Changing Health Plan: IT'S YOUR CHOICE ENROLLMENT PERIOD
Event Date: 09/29/2015 MM/DD/YYYY
Employer Received Date: 09/29/2015 MM/DD/YYYY
You are requesting a change in health plan for member and all dependents.
Health Plan
Coverage Level
Begin Date
End Date
Status
Employer
GHC SOUTH CENTRAL WI DENTAL
SINGLE
01/01/2013
12/31/2015
PENDING
EMPLOYEE TRUST FUNDS, DEPT OF P01/S01 $648.60
Non-HDHP Health Plan
No Dental Plan
GHC SOUTH CENTRAL WI
SINGLE
01/01/2016
PENDING
EMPLOYEE TRUST FUNDS, DEPT OF P01/S01 $648.60
Row
SSN
Name - First, MI, Last, Suffix
DOB
Gender
Relationship
Tax Dep
Disabled
Physician
1
SELF
NO
NO
YES
Insurance: NO
Other Insurance Co:
Group No:
Policy No:
Medicare: NO
Medicare: Select
Claim No:
Med A Eff Dt:
Med B Eff Dt:
Medicare Info Blank Reasons: Select
Physician Info-National Provider Id:
Physician Last/Clinic Name:
WNGRA FAI
First Name:
Submit
Cancel