

**LOCAL
GOVERNMENT
ANNUITANT
OR
CONTINUANT
ONLY**

Instructions:

To change plans or change to Family coverage, complete all sections of this form in ink. See page H-2 in the Dual-Choice book for more information. If you want to retain your current coverage, do not complete this form.

PLEASE PRINT

GROUP: LOCAL GOVERNMENT ANNUITANT OR CONTINUANT			DUAL-CHOICE			HEALTH INSURANCE APPLICATION			
Applicant – Last Name		First		Middle			Social Security Number		
Address – Street & No.		City		State		ZIP Code		County	
Home Telephone Number ()									
Marital Status <input type="checkbox"/> Single		Married <input type="checkbox"/> Date _____		Divorced <input type="checkbox"/> Date _____		Separated <input type="checkbox"/> Date _____		Widowed <input type="checkbox"/> Date _____	
Spouse's/Ex-Spouse's Name & Social Security Number				OTHER HEALTH INSURANCE COVERAGE (<i>You must complete this section</i>)					
CURRENT GROUP HEALTH INSURANCE PLAN Plan Name _____ Group No. _____				Are you or a family member insured under Medicare? <input type="checkbox"/> No <input type="checkbox"/> Yes					
				If yes, list names of insured and Medicare effective dates. Name: _____ Dates: Part A _____ Part B _____ Name (spouse): _____ Dates: Part A _____ Part B _____					
NEW GROUP HEALTH INSURANCE PLAN SELECTED Plan Name _____ <i>(list complete name, including location if part of name)</i>				Are you or a family member insured under another health insurance plan? <input type="checkbox"/> No <input type="checkbox"/> Yes					
				If yes, list names of insured and plan. Name: _____ Name (Spouse): _____ Plan Name (Insurance Co.): _____ Group No.: _____ Subscriber (Policy) No.: _____ Name of Employer: _____					
COVERAGE DESIRED <input type="checkbox"/> Single <input type="checkbox"/> Family									

Last Name	First	Middle	Birthdate			Sex M/F	Social Security Number	(see page H-2)		YOU MUST INDICATE SELECTED PRIMARY PHYSICIAN, COUNTY in which located, and PROVIDER NUMBER (if available). Indicate NONE if electing the Standard Plan.		
			MO	DAY	YR			App. Rel. Code	Student Status			
Applicant								N/A	N/A	PHYSICIAN NAME First & Last	PHYSICIAN'S COUNTY	PROVIDER NUMBER
Spouse								N/A	N/A			
Eligible Dependent(s)												

I apply for the insurance under the indicated health insurance contract made available to me through the State of Wisconsin and under the terms and conditions as described on the reverse side of this application. A copy of this application is to be considered as valid as the original. **Submit form with original signature.**

<input type="checkbox"/> I am a retiree or surviving spouse/dependent <input type="checkbox"/> I am on continuation (eligible for a maximum of 36 months' coverage)	DATE SIGNED (MM/DD/CCYY)	SIGN HERE	APPLICANT SIGNATURE
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Return completed form to: Employee Trust Funds
 P.O. Box 7931
 Madison, WI 53707-7931

Upon receipt and acceptance by ETF, coverage will be **effective 01/01/2005**

FOR DEPARTMENT OF EMPLOYEE TRUST FUNDS USE ONLY					
ENROLLMENT TYPE 40	EMPLOYEE TYPE	COVERAGE CODE	CARRIER SUFFIX	PARTICIPANT'S COUNTY	PROVIDER'S COUNTY
EIN 0000-001	Group Number 77	ETF Contact Person		Telephone (608)	
Monthly Premium \$	Date Received	COBRA Coverage Expires		Effective Date 01/01/2005	

TERMS AND CONDITIONS

1. To the best of my knowledge, all statements and answers in this application are complete and true. All information is furnished under penalty of Wis. Stat. § 943.395.
2. I agree to pay the current premium for this insurance.
3. 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, my spouse or any dependents. If medical records are needed, my health plan and/or ETF will provide me with an authorization form.
4. Any children, as defined, listed on this application are unmarried and dependent on me, or the other parent, for at least 50% of support and maintenance. If over the age of 19, they are a full-time student; if over the age of 25, they are disabled of long standing duration and are incapable of self-support.
5. I understand that coverage will be cancelled and cannot be reinstated if premiums are not paid when due.