

**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**

<b>GROUP: LOCAL GOVERNMENT ANNUITANT OR CONTINUANT</b>			<b>DUAL-CHOICE</b>			<b>HEALTH INSURANCE APPLICATION</b>			
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> )					
<b>CURRENT GROUP HEALTH INSURANCE PLAN</b> 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 _____ Part D _____ Name (spouse): _____ Dates: Part A _____ Part B _____ Part D _____					
<b>NEW GROUP HEALTH INSURANCE PLAN SELECTED</b> 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: _____					
<b>COVERAGE DESIRED</b>									
<input type="checkbox"/> Single <input type="checkbox"/> Family									

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

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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	DATE SIGNED (MM/DD/CCYY)	<b>SIGN HERE</b>
<input type="checkbox"/> I am on continuation (eligible for a maximum of 36 months' coverage)		APPLICANT SIGNATURE

**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 01/01/2006**

FOR DEPARTMENT OF EMPLOYEE TRUST FUNDS USE ONLY					
ENROLLMENT TYPE <b>40</b>	EMPLOYEE TYPE	COVERAGE CODE	CARRIER SUFFIX	PARTICIPANT'S COUNTY	PROVIDER'S COUNTY
EIN <b>0000-001</b>	Group Number <b>77</b>	ETF Contact Person		Telephone (608)	
Monthly Premium <b>\$</b>	Date Received	COBRA Coverage Expires		Effective Date 01/01/2006	

## 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 authorize Employee Trust Funds ETF to obtain any information from any source necessary to administer this insurance.
3. I agree to pay the current premium for this insurance. I understand that coverage will be cancelled and cannot be reinstated if premiums are not paid when due.
4. 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.
5. 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. Children may be covered through the end of the year in which they turn 19; or if they are full-time students, coverage continues through the end of the year in which they cease to be a full-time student or turn age 25. Children may also be covered beyond age 19 if they have a disability of long standing duration and are incapable of self-support.
6. I understand it is my responsibility to notify the employer, or if I am an annuitant or continuant to notify ETF, if there is a change affecting my coverage, including but not limited to, a change in eligibility due to divorce or marriage, or an address change due to a residential move. Furthermore, failure to notify the employer may result in loss of coverage, delay in payment of claims and/or loss of continuation rights.
7. I understand that if there is a qualifying event in which a qualified beneficiary (me, my spouse or any dependents) ceases to be covered under this program, the participant(s) may elect to continue group coverage as permitted by state or federal law for a maximum of 36 months from the date of the qualifying event or the date of the notice to my employer, whichever is later. I also understand that if continuation coverage is elected by the affected qualified beneficiary and there is a second qualifying event (i.e, loss of eligibility for coverage due to death, divorce, marriage but not including non-payment of premium) or a change in disability status as determined by the Social Security Administration, continuation coverage, if elected subsequent to the second qualifying event, will not extend beyond the maximum of the initial 36 months of continuation coverage. I understand that notification of these events must be made to ETF in order to take advantage of the maximum 36 months.