

HEALTH INSURANCE INFORMATION CHANGE

This form is to be completed by a subscriber who is only revising relevant information. Transactions such as changing HMOs or changing from single to family coverage require a new health application (ET-2301) and should not be submitted on this form.

SUBSCRIBER: Complete Sections 1-5. Return form to employer (or ETF if an annuitant).

- Name _____ Birthdate _____ Social Security Number _____
Health Insurance Plan _____ Present Coverage: Single Family
Subscriber # _____ Group # _____
(If retiree or continuant)
I was a dependent or spouse of (name): _____ Social Security Number _____
- Check the box(es) indicating the type(s) of change(s): Event Date _____
 Name change (list former name) _____
 Address change to: Street: _____
County _____ City: _____ State: _____ Postal Code: _____
 Home Phone # _____ Daytime Telephone # _____
 Social Security Number _____ for _____
 Selected physician or clinic change to: _____ for _____
Change in subscriber's physician or clinic county? No Yes, county is _____
 Update other insurance coverage for: _____
Through State of WI, including University of WI? No Yes Name of Insured _____
Insurance Company _____ Name of Employer _____
Group # _____ Subscriber/Policy # _____ Effective Date _____ Medicare? No Yes
- Complete the following when **adding** a dependent, please list the event date in the grid below (*applicant relationship code on reverse side*):
Reason: Marriage Student Status Changed Birth Legal Ward* Adoption* Disabled
**Please attach documentation for additions due to legal ward or adoption status*
Is spouse State of WI employee, including University of WI? Yes No

Last Name	First	Middle	Birthdate			Gender M/F	Social Security Number	Applicant Rel. Code	Selected Physician or Clinic		Event Date
			Mo	Da	Yr				Last Name	First	

Dependents include spouse and children. Children include those who are dependent upon you and/or the other parent for at least 50% of their support, meet the support tests as a dependent for federal income tax purposes and are your natural children, legal wards who become your permanent ward prior to age 19, adopted children, stepchildren, or children of your dependent child until your child reaches age 18.

- Complete the following for **deleting** a dependent. Please list the event date in the grid below:
[Do not use this form to remove last dependent. Please complete new health application (ET-2301) to change to single coverage.]
Reason: Divorce Age* Dependent Married Student Status Changed Other _____
**Dependent turned 19 and is not a full-time student; full-time student turned 25; grandchild of a dependent that turned 18.*

Last Name	First	Middle	Birthdate			Gender M/F	Social Security Number	Event Date	Dependent's Address (if different than subscriber's)
			Mo	Da	Yr				

NOTE: THE DELETION OF A DEPENDENT DUE TO LOSS OF ELIGIBILITY PROVIDES AN OPPORTUNITY FOR CONTINUATION COVERAGE (COBRA) UP TO 36 MONTHS PROVIDED NOTICE IS GIVEN TO THE EMPLOYER WITHIN 60 DAYS OF EVENT.

5. I have read and understand the Terms and Conditions on the reverse side. _____
Subscriber Signature _____ Date _____

EMPLOYER COMPLETES AREA BELOW Coding Instructions are in the Employer Health Insurance Manual							
Enrollment Type 65	Employee Type	Coverage Code	Carrier Suffix	Participant County	Physician County	Program Option Code	Surcharge Code
Name of Employer				Employer Number 69-036-	Group Number	Date Received by Employer (MM/DD/CCYY)	
Monthly Employee Share \$	Monthly Employer Share \$	Date Employment Began (MM/DD/CCYY)		Event Date (MM/DD/CCYY)		Prospective Date of Coverage (MM/DD/CCYY)	
Payroll Representative Signature					Telephone ()		

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 the State of Wisconsin Department of Employee Trust Funds (ETF) to obtain any information from any source necessary to administer this insurance.
3. I agree to pay in advance the current premium for this insurance and I authorize the remitting agent (i.e., employer) to deduct from my wages or salary an amount sufficient to provide for regular premium payments that are not otherwise contributed. The remitting agent shall send the premium on my behalf to ETF.
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. Upon request, I agree to provide such documentation that ETF deems necessary to substantiate subscriber or dependent eligibility.
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.
8. I agree to abide by the terms of my benefit plan, as explained in any written materials I receive from ETF or my health plan, including, without limitation, the ***It's Your Choice*** booklet.

Applicant Relationship Codes	
01 – Spouse	19 – Child
15 – Legal Ward	24 – Dependent of a minor dependent
17 – Stepchild	