Health Insurance Application/Change

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

There are certain times throughout the year when you may enroll in health insurance or change your coverage. Visit etf.wi.gov/benefits-by-employer to learn more about choices available to you and see how to enroll. **Return this completed form to your employer. Print clearly.** Please read the terms and conditions on page 6. Sign on page 4.

Your health insurance deductions will be taken pre-tax unless you request they be taken post-tax. Contact your employer to make this change or submit the *Automatic Premium Conversion Waiver/Revocation of Waiver* (ET-2340) to your employer.

1. Applicant Information *Only the subscriber applying for coverage/making a change should complete this form.*

Check here if your name, phone, address, email, or marital status has changed: ☐ *List updated information below*

Name First	M.I.	Last	Former/Maiden (if applicable)

ETF ID	SSN or ITIN	Telephone, including area code	Email

Mailing address (Street) City State ZIP code Country

Birth date (MM/DD/YYYY)	Sex ☐ Male ☐ Female	Primary care physician or clinic *Health plan may also ask*

Check your marital status:

☐ Single *(no change date required)*

☐ Married Date: _____ (MM/DD/YYYY)

☐ Divorced Date: _____ (MM/DD/YYYY)

☐ Widowed Date: _____ (MM/DD/YYYY)

Please check which applies to you (this determines your eligibility)

☐ Employee ☐ Graduate assistant ☐ COBRA recipient ☐ Surviving dependent

2. Spouse Information (Only complete if you are on a family plan; not required for single coverage)

Name First	M.I.	Last	Former/Maiden	SSN or ITIN

Birth date (MM/DD/YYYY)	Sex ☐ Male ☐ Female	Primary care physician or clinic *Health plan may also ask*

Check here if your spouse's information has changed: ☐

3. Dependent Information (Only complete if you are on a family plan; this does not include spouse)

Name *You may attach additional pages if more space is needed*			SSN or ITIN	Birth date	Sex (M/F)	Relationship (child, stepchild, legal ward, child of minor dependent)	Disabled (Y/N)	Primary care physician or clinic *Health plan may also ask*
First	*M.I.*	*Last*						

Is any dependent listed here your or your spouse's grandchild? ☐ Yes ☐ No

If yes, name of parent: _____

Name: _____ ETF ID: _____

4. Are you eligible to enroll or make a change?

You can modify your benefits during the annual open enrollment period, your initial hire period, and in response to an eligible life event change. Eligible life changes are listed below.

Reason for Application: Select a reason for enrolling or changing your coverage or health plan:

- ☐ Annual open enrollment (coverage effect January 1).
- ☐ New hire (Choose date your coverage will be effective, see below).
- ☐ Rehired annuitant.
- ☐ Eligible life event change (select change below). Life event change date: _____
- ☐ Eligible move to a new service area *(may only change health plan)*. Move date: _____

New hires or employees returning from leave (lapsed coverage) *only*: Choose your coverage to be effective:

- ☐ When my employer contributes to my premium.
- ☐ As soon as possible (you will pay the entire monthly premium until you are eligible for your employer contribution).
- ☐ I choose to decline/waive coverage *(to decline health insurance and elect the opt-out incentive, go to section 12).*
- ☐ I choose to decline/waive coverage *because I have other health insurance coverage (go to section 13 and sign).*

Eligible life event changes, which allow you to make a change outside of the annual open enrollment period (or your initial hire period), include birth/adoption, marriage and divorce. Visit etf.wi.gov/insurance/life-events-guide for more.

Select one reason to add coverage/dependent or remove dependent(s):

Add coverage/dependent(s) *(complete section 3)*

- ☐ Marriage*
- ☐ Transfer to a new state agency (state only)
  Former agency name: _____
- ☐ Birth or adoption*
- ☐ LTE new hire (state only)
- ☐ Enroll in COBRA (*Continuation-Conversion Notice* (ET-2311) required)
- ☐ National Medical Support Notice*
- ☐ Spouse-to-spouse transfer at retirement
- ☐ Loss of employer contributions or loss of other coverage*
- ☐ Paternity acknowledgment*
- ☐ Legal ward/guardianship*
- ☐ Disabled dependent, age 26+*
- ☐ Dependent not on initial enrollment (excludes adult dependents)
- ☐ Other: _____

Remove dependent(s) *(complete section 8)*

- ☐ Divorce*
- ☐ Death of dependent
- ☐ Legal ward/guardianship end*
- ☐ Disabled dependent disability end or support/maintenance less than 50%
- ☐ Grandchild's parent age 18
- ☐ Adult dependent eligible for other coverage*
- ☐ Other: _____

**You may be required to provide supporting documentation.*
See etf.wi.gov/life-change-event-documentation

5. Enroll in a Plan Design

Compare factors like monthly payments, coverage levels, out-of-network benefits, and provider availability. See your insurance benefits materials or your employer for specific options available to you, and descriptions of each plan design. If you are not changing the options below, you do not need to complete this section.

Make your plan (chosen on next page) a High Deductible Health Plan (HDHP)? ☐ Yes ☐ No

Individual or family coverage? ☐ Individual ☐ Family

With or without Uniform Dental? ☐ With dental ☐ Without dental

If you choose with dental, your dental plan will be Delta Dental.

State employees: If you elect HDHP, you must also enroll in the state-sponsored health savings account (HSA). You are not eligible for an HDHP if you have other coverage. You may enroll in an HDHP if your dependents have other coverage.

Local Wisconsin Public Employer (WPE) employees: You can only enroll in the plan designs your employer offers, including dental. Check with your employer.

6. Select Your Health Plan

All health plans provide the same in-network benefits. When choosing a plan, consider where you live or work, health plan quality ratings and the monthly premium. See your insurance benefits materials for your options. Health plan provider directories are available online.

- ☐ Access Plan by Dean Health Plan
- ☐ Aspirus Health Plan
- ☐ Common Ground Healthcare Cooperative
- ☐ Dean Health Plan
- ☐ Dean Health Plan - Medica West and Mayo Clinic Health System
- ☐ Dean Health Plan - Prevea360 East
- ☐ GHC of Eau Claire Greater Wisconsin
- ☐ GHC of Eau Claire River Region
- ☐ GHC of South Central Wisconsin Dane Choice
- ☐ GHC of South Central Wisconsin Neighbors
- ☐ HealthPartners Health Plan Southeast
- ☐ HealthPartners Health Plan West
- ☐ Medical Associates Health Plans
- ☐ MercyCare Health Plans
- ☐ Network Health
- ☐ Quartz Central
- ☐ Quartz UW Health
- ☐ Quartz West
- ☐ Robin with HealthPartners
- ☐ Security Health Plan
- ☐ State Maintenance Plan (SMP) by Dean Health Plan

7. Complete if you or any of your Dependents are Covered by Medicare

Required for all persons covered by Medicare, including yourself. Eligibility reasons include age, disability or end-stage renal disease (ESRD).

Name (*First, M.I., Last*)	Medicare number (see your Medicare ID card)	Part A effective date	Part B effective date	Why eligible?
				☐ Age ☐ Disability ☐ ESRD
				☐ Age ☐ Disability ☐ ESRD
				☐ Age ☐ Disability ☐ ESRD

8. Remove a Spouse or Dependent(s)

Name of person(s) you are removing *(First, M.I., Last)*	Birth date	Address (if different than your address on page 1)

9. Complete if you are Changing from Family to Individual Coverage

If your employee monthly premium share is pre-tax, IRC Section 125 restricts midyear changes to your coverage. For more information on IRC Section 125 limitations, visit www.irs.gov.

My employee-required monthly premium contribution is deducted (*check one*):

- ☐ Pre-tax and my employee premium contribution has increased significantly
- ☐ Pre-tax eligible life event change

  What was the event? _____
- ☐ Pre-tax change to individual during annual open enrollment period (January 1)
- ☐ Post-tax (midyear changes to coverage level can be made at any time)

  Event date: _____

Name: _____ ETF ID: _____

10. Cancel Health Insurance Coverage

Only complete this section to cancel coverage entirely. Do not complete if you are changing health coverage.

My premiums are deducted: ☐ Pre-tax (select a life change event below)
☐ Post-tax (no event required to cancel coverage)

Choose one reason for canceling coverage:

☐ Open enrollment; cancel all coverage for next year

☐ I am terminating employment

☐ My employee premium share has increased significantly

☐ I and all eligible dependents are now eligible for, and enrolled in, other coverage

Event date: _____ *(you must provide proof)*

☐ Spouse-to-spouse transfer at retirement

Event date: _____

☐ I am going on an unpaid leave of absence *(you may want to let your coverage lapse instead; see your employer)*

Your cancellation is effective on the first of the month after ETF receives your written request to cancel, unless you specify a later date, above.

11. Do you Have Other Health Insurance Coverage

Do you or any of your dependents also have other medical coverage or health care flexible spending account coverage that has a balance available as of the effective date of this coverage (excludes dental or vision)? (Coordination of benefits will apply.)

☐ No

☐ Yes (complete other health insurance information below)

Name of health insurance company:_____

Policy number: _____ Group number: _____

Name(s) of insured: _____

12. *State Employees Only*: Decline Health Insurance & Elect the Opt-Out Incentive

Are you electing to receive the opt-out incentive for 2025? ☐ Yes ☐ No

If yes, you certify you are eligible for the opt-out stipend and are not currently, nor will be this program year, a covered dependent under the State of Wisconsin Group Health Insurance Program, and that you did not decline or waive coverage in 2015.

13. Subscriber Signature *Required* If not signed, ETF cannot accept your 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* (see page 6). 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.

Subscriber signature	Date (MM/DD/YYYY)

Return this completed form to your employer.

If you are enrolling in COBRA, return this completed form to ETF.

Employer must review the completed application before completing the employer section on the next page.

Name: _____ ETF ID: _____

Employer Completes – complete entire section, including the signature

Employer must review the completed employee application before completing and signing this section.
Coding instructions are in the *Employer Health Insurance Administration Manual*.

EIN	Employer name		Payroll representative email
Group number	Employee type	Coverage type ☐ Individual ☐ Family	Health plan name/suffix
Business Unit *(if applicable)*	Employment status of applicant ☐ Full time ☐ Part time ☐ LTE		Employee deductions ☐ Pre-tax ☐ Post-tax
Hire date or date WRS-eligible employment or graduate appointment began	Employer received date	Event date	Prospective coverage date

Are you a WRS-participating employer? ☐ Yes ☐ No

Previous service check completed? ☐ Yes ☐ No

Source of previous service check? ☐ WRS System ☐ ETF

Did employee participate in the WRS prior to being hired by you? ☐ Yes ☐ No

Payroll representative signature	Telephone, including area code	Date signed (MM/DD/YYYY)

Terms and Conditions

To the best of my knowledge, all statements and answers in this application are complete and true. I understand that if I provide false or fraudulent information, misrepresentation or fail to provide complete or timely information on this application, I may face action, including, but not limited to, loss of coverage, employment action, and/or criminal charges/sanctions under Wis. Stat. § 943.395.

I authorize the Department of Employee Trust Funds to obtain any information from any source necessary to administer this insurance.

I agree to pay in advance the current premium for this insurance, and I authorize my employer (the remitting agent) 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.

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 or any dependent(s). If medical records are needed, my health plan and/or ETF will provide me with an authorization form. I agree to respond to questions from health plans and ETF, including, but not limited to, audits, in a timely manner.

I have reviewed and understand the eligibility criteria for dependents under this coverage and affirm that all listed dependents are eligible. I understand that children may be covered through the end of the month they turn 26. Children may also be covered beyond age 26 if they: have a disability of long standing duration, are dependent on me or the other parent for at least 50% of support and maintenance, and are incapable of self-support; or are full-time students and were called to federal active duty when they were under the age of 27 years and while they were attending, on a full-time basis, an institution of higher education.

I understand that it is my responsibility to notify the employer, or if I am a retiree 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, marriage or an address change due to a residential move. Furthermore, failure to provide timely notice may result in loss of coverage, delay in payment of claims, loss of continuation rights and/or liability for claims paid in error. Upon request, I agree to provide any documentation that ETF deems necessary to substantiate my eligibility or that of my dependent(s).

I understand that if there is a qualifying event in which a qualified beneficiary (me or any dependent(s)) ceases to be covered under this program, the beneficiary(ies) may elect to continue group coverage as permitted by state or federal law for a maximum of 18, 29, or 36 months, depending on the type of qualifying event, from the date of the qualifying event or the date of the notice, whichever is later. I also understand that if continuation coverage is elected by the affected qualified beneficiary(ies) 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 months of continuation coverage. I understand that timely notification of these qualifying events must be made to ETF.

I understand that if I am declining enrollment for myself or my dependent(s) (including spouse) because of other health insurance coverage, I may be able to enroll myself and my dependent(s) in this plan if I or my dependent(s) lose eligibility for that other coverage (or if the employer stops contributing toward that other coverage). However, I must request enrollment within 30 days after my or my dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if I have (a) new dependent(s) as a result of marriage, birth, acknowledgement of paternity, adoption, or placement for adoption, I may be able to enroll myself and my dependent(s) if I request enrollment within 30 days after the marriage or within 60 days after the birth, acknowledgement of paternity, adoption, or placement for adoption. To request special enrollment or obtain more information, I should contact my employer (or ETF if I am a retiree or continuant).

I understand that I am responsible for enrolling in Medicare Parts A and B when I am first eligible and required by this coverage, and that as the subscriber I am responsible for ensuring my spouse and any other eligible dependents also enroll in Medicare Parts A and B when they are first eligible, to ensure proper coordination of benefits with Medicare. In the event I or any eligible dependent does not enroll in Medicare Parts A and B when first eligible and required by this group health insurance program, I understand that I will be financially liable for the portion of claims Medicare would have paid had proper Medicare enrollment been attained.

I understand that if I enrolled in IYC Medicare Advantage with an individual or family contract and subsequently I or my dependents cancel Medicare coverage, I and all covered dependents on the contract will be unenrolled from the IYC Medicare Advantage plan and enrolled in the Medicare Plus plan effective the date of loss of Medicare coverage. I understand that I will be financially liable for the portion of claims Medicare would have paid had proper Medicare enrollment been attained.

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 insurance materials.

Nondiscrimination and Language Access

42 U.S. Code § 18116

ETF complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

ETF provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats and others). ETF provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact ETF at 1-877-533-5020; TTY: 711.If you believe that ETF has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

ETF Office of Policy, Privacy & Compliance
P.O. Box 7931
Madison, WI 53707-7931

1-877-533-5020; TTY: 711
Fax: 608-267-4549
Email: ETFSMBPrivacyOfficer@etf.wi.gov

If you need help filing a grievance, ETF's Office of Policy, Privacy & Compliance is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal at ocrportal.hhs.gov/ocr/smartscreen/main.jsf or by mail or phone:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

1-800-368-1019; 1-800-537-7697 (TDD)

Complaint forms are available at hhs.gov/ocr/complaints/index.html.

The Wisconsin Department of Employee Trust Funds is a state agency that administers the Wisconsin Retirement System pension, health insurance and other benefits offered to eligible government employees, former employees and retirees.

Spanish – ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-533-5020 (TTY: 711).

Hmong – LUS CEEV: Yog tias koj xav tau kev pab txhais lus. Peb pab koj tau, peb pab koj dawb xwb, thov hu rau 1-877-533-5020 (TTY: 711)

Chinese– 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-533-5020（TTY：711）

German – ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-533-5020 (TTY: 711).

ملاحظة: إذا كنت تتحدث اللغة العربية، فهناك خ
متاحة بلغتك دون أي مصاريف: اتصل بالرقم
1-877-533-5020 (خدمة الصم والبكم: 711)

Russian – ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-533-5020 (телетайп: 711).

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-533-5020 (TTY: 711)번으로 전화해 주십시오.

Vietnamese – CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-533-5020 (TTY: 711).

Pennsylvania Dutch – Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-877-533-5020 (TTY: 711).

Laotian/Lao – ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີ ພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-877-533-5020 (TTY: 711).

French – ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement.
Appelez le 1-877-533-5020 (ATS : 711).

Polish – UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwońpod numer 1-877-533-5020 (TTY: 711).

Hindi – ध्यान दें: यदि आप ि दी बोलते ै तो आपके लिए मुफ्त में भाषा स ायता सेवाएं उपलब्ध ै। 1-877-533-5020 (TTY: 711) पर कॉल करें।

Albanian – KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, papagesë. Telefononi në 1-877-533-5020 (TTY: 711).

Tagalog – PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-533-5020 (TTY: 711).

Health Plan Contact Information

Aspirus Health Plan
3000 Westhill Dr., Suite 303
Wausau, WI 54401
Telephone: 1-866-631-8583
Fax: 715-843-1246
1-833-811-4176
Website: p1.aspirushealthplan.com/etf

Common Ground Healthcare Cooperative
Offered in partnership with GHC of Eau Claire
2503 N. Hillcrest Parkway
Altoona, WI 54720
Telephone: 1-833-742-0952
Fax: 715-552-3500
Website: group-health.com/members/state-of-wi-ghcec-cghc

Dean Health Plan
1277 Deming Way
Madison, WI 53717
Telephone: 1-800-279-1301
Fax: 608-827-4212
Dean On Call: 1-800-576-8773
Website: deancare.com/wi-employees

Dean Health Plan - Prevea360
2710 Executive Drive
Green Bay, WI 54304
Telephone: 1-877-230-7555
Fax: 1-608-827-4212
Prevea Care After Hours: 1-888-277-3832
Website: prevea360.com/wi-employees

Group Health Cooperative of Eau Claire (GHC-EC)
P.O. Box 3217
Eau Claire, WI 54702
Telephone: 1-888-203-7770, 715-552-4300
Fax: 715-552-3500
Website: group-health.com

Group Health Cooperative of South Central Wisconsin (GHC-SCW)
1265 John Q. Hammons Drive
P.O. Box 44971
Madison, WI 53717-4971
Telephone: 1-800-605-4327, 608-828-4853
Fax: 608-662-4186
Website: ghcscw.com

HealthPartners Health Plan
P.O. Box 1309
Minneapolis, MN 55440-1309
Telephone: 1-855-542-6922, 952-883-5000
Fax: 952-883-5666
Website: healthpartners.com/stateofwis

Medical Associates Health Plans
1605 Associates Drive, Suite 101
Dubuque, IA 52002
Telephone: 1-866-421-3992
Fax: 563-584-4760
Website: mahealthcare.com

MercyCare Health Plans
580 N. Washington Street
P.O. Box 550
Janesville, WI 53547-0550
Telephone: 1-800-895-2421 option 5
Fax: 608-752-3751
Website: mercycarehealthplans.com

Navitus Health Solutions
P.O. Box 999
Appleton, WI 54912-0999
Telephone: 1-844-268-9789
Website: navitus.com

Navitus MedicareRx (PDP)
(Prescription drug coverage for Medicare-eligible retirees)
P.O. Box 1039
Appleton, WI 54912-1039
Telephone: 1-866-270-3877
Website: medicarerx.navitus.com

Network Health
1570 Midway Place
P.O. Box 120
Menasha, WI 54952
Telephone: 1-844-625-2208, 920-720-1811
Fax: 920-720-1909
Website: networkhealth.com/employer/state

Quartz
2650 Novation Parkway
Fitchburg, WI 53713
Telephone: 1-844-644-3455
Fax: 608-643-2564
Website: ChooseQuartz.com

Robin with HealthPartners
P.O. Box 1309
Minneapolis, MN 55440-1309
Telephone: 1-855-542-6922, 952-883-5000
Fax: 952-883-5666
Website: healthpartners.com/etfrobin

Security Health Plan
1515 North Saint Joseph Avenue
P.O. Box 8000
Marshfield, WI 54449-8000
Telephone: 1-844-813-7286, 715-221-9555
Fax: 715-221-9500
Website: securityhealth.org/state

UnitedHealthcare
P.O. Box 29675
Hot Springs, AR 71903-9675
Telephone: 1-844-876-6175
Website: UHCRetiree.com/etf