Health Insurance Application/Change For Retirees & COBRA Continuants

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 instructions on how to enroll. **Return this completed form to ETF.** Please print clearly. Please read the terms and conditions on page 7.

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

Name *First*	*M.I.*	*Last*	ETF ID or SSN

Former/Maiden (if applicable)	Telephone ( )	Email

Mailing address	City	State	ZIP code	Country

Physical street address *(if different from above)*	City	State	ZIP code	Country

Note: If you are selecting Medicare Advantage and use a P.O. Box for your mailing address, you must also provide a physical street address to comply with Medicare requirements.

Birth date	Gender ☐ Male ☐ Female	Primary care physician or clinic

Check your marital status:

☐ Single *(no change date required)*

☐ Married Date: _____ (MM/DD/YYYY)

☐ Divorced Date: _____ (MM/DD/YYYY)

☐ Widowed Date: _____ (MM/DD/YYYY)

Check here if your name, phone, address, email or marital status has changed: ☐ *Provide current information above*

2. Spouse Information (if adding or covered on your plan)

Name *First*	*M.I.*	*Last*	*Former/Maiden*	SSN

Birth date	Gender ☐ Male ☐ Female	Primary care physician or clinic

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

3. Dependent Information (if adding or covered on your plan)

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

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

If yes, name of parent: _____

4. Why are you making a change?

Reason for application: Select a reason for enrolling or changing your coverage or health plan (see life events on page 5):

- ☐ Health benefits enrollment (coverage effective January 1).
- ☐ Sick leave re-enrollment *(state retirees only).* Date to re-enroll if other than January 1:_____
- ☐ Eligible life event change. Life event (e.g. marriage, new to Medicare, loss of coverage, etc.):_____ Event date:_____
- ☐ Eligible move to a new service area *(may only change health plan).* Move date:_____
- ☐ Change from family to individual coverage.
- ☐ Newly eligible for local annuitant health program (LAHP). You must file an application to enroll within 60 days of your last day of employment and first annuity (or lump-sum) payment. You may also apply when you first enroll in Medicare Part B. See LAHP brochure (21ET-2156). LAHP enrollment may be delayed up to 90 days. Effective date (MM/DD/YYYY):_____
- ☐ Spouse-to-spouse transfer. Event date: _____
- ☐ Disability approval (*ETF use only*).

Eligible life event changes, which allow you to make a change outside of the annual health benefits open enrollment, include marriage, divorce or guardianship.

State retirees with escrowed, accumulated sick leave conversion credits may re-enroll in health insurance during open enrollment, or after a loss of coverage. The retiree must have comparable health insurance coverage. For more information, see the *Sick Leave Credit Escrow Application* (ET-4305) on the ETF website.

Visit etf.wi.gov for a *Life Change Event Guide*; see page 5 for documentation requirements. You may be required to provide supporting documentation. *If adding or removing dependents, see section 3.*

5. Enroll in a Plan Design & Health Plan

Complete either 5a or 5b below. Be sure to list the entire health plan name. Compare factors like monthly payments, coverage levels and out-of-network benefits availability.

State retirees: If you elect the High Deductible Health Plan (HDHP), you must also enroll in the state-sponsored health savings account (HSA). You are not eligible if you have Medicare, other health, and/or flexible spending account (FSA) coverage. Dependents can have other coverage, and you can still have an HDHP policy.

Local WPE retirees: You may only choose an HDHP if your previous employer offered it; check with ETF if you are not sure.

5a. If *no one* on your Plan has Medicare:

If any insured participants (or you) are on Medicare, go to "If anyone on your plan *has* Medicare," below.

Select a Plan Design:

- ☐ IYC Health Plan *(Name a health plan below.)*
- ☐ Access Plan *(Your health plan will be WEA Trust. Skip name a health plan section below.)*
- ☐ High Deductible Health Plan (HDHP) *(Name a health plan below.)*
- ☐ Access High Deductible Health Plan (HDHP) *(Your health plan will be WEA Trust. Skip name a health plan section below.)*

Name a Health Plan *All health plans provide the same in-network benefits. When choosing a plan, consider where you live or work, health plan performance ratings and the monthly premium. See your health benefits materials for your options.*

Enter the complete health plan name here: _____

5b. If anyone on your plan *has* Medicare:

Complete this section if any insured participants (or you if you have an individual plan) are on Medicare:

Plan Design for Participants *with* Medicare:

You must have both Medicare Parts A and B.

- ☐ IYC Medicare Advantage *(Your health plan will be UnitedHealthcare®.)*
- ☐ IYC Medicare Plus *(Your health plan will be WEA Trust.)*
- ☐ Health Plan Medicare Complete health plan name: _____

Note: If any participants are Medicare eligible and select Health Plan Medicare, the non-Medicare participants must be covered under the same health plan name.

List all participants enrolled in Medicare in section 7.

Plan Design for Participants *without* Medicare:

Complete if you have non-Medicare members on your insurance.

- ☐ IYC health plan Complete health plan name: _____
- ☐ Access Plan *(Your health plan will be WEA Trust.)*
- ☐ High Deductible Health Plan (HDHP) Complete health plan name: _____
- ☐ Access High Deductible Health Plan (HDHP) *(Your health plan will be WEA Trust.)*

Name: _____ ETF ID: _____

6. Choose Individual or Family Coverage, and With or Without Dental.

Individual (only you) or family (you and your dependents) coverage? ☐ **Individual** ☐ **Family**

With or without dental? ☐ **With dental** ☐ **Without dental**

Local Wisconsin Public Employer (WPE) retirees: You may only choose Uniform Dental Benefits if your former employer offers it. Check with ETF if you are not sure.

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 (F*irst, M.I, Last*)	Medicare number	Part A effective date	Part B effective date	Why eligible?
				☐ Age ☐ Disability ☐ ESRD
				☐ Age ☐ Disability ☐ ESRD
				☐ Age ☐ Disability ☐ ESRD
				☐ Age ☐ Disability ☐ ESRD

8. Cancel Health Insurance Coverage

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

☐ Voluntarily cancel all coverage, as of the first of _____(month).

Your cancellation is effective on the first of the month after ETF receives your request to cancel, unless you specify a later date, above. This includes all family members on your plan if you have family coverage.

9. Complete if you Have Additional Health Insurance/Coverage

Do you or any of your dependents 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) ☐ Yes ☐ No **If yes:**

Company	Policy number	Group number

Name(s) of insured (F*irst, M.I., Last*)

10. Signature *Required*

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 7). 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.

Signature	Date

Additional Information: Life Event: Becoming Eligible or Ineligible for Medicare
When you or someone on your health insurance becomes eligible or ineligible for Medicare, you can make changes to your health insurance. You can change health plans or plan designs—or cancel coverage.

You must file an application within 30 days of the Medicare coverage change. You can file sooner, if you apply to enroll in Medicare up to three months before your 65th birthday. Your change will be effective on the date of the Medicare coverage change.

Frequently Asked Questions: "Medicare Family Some" Coverage with Medicare Plus or Medicare Advantage

1. How will our medical out-of-pocket limits (OOPLs) and deductible work?
   Medical claims for Medicare members and non-Medicare members add up separately. That means when a non-Medicare member pays for a medical service, it will count towards the non-Medicare deductible and out-of-pocket limit. It will not count towards the Medicare out-of-pocket limit.

   Prescription drug costs for Medicare and non-Medicare members will add up to one family out-of-pocket limit.

2. What happens if we are covered by two health plans and one of us becomes eligible for Medicare?
   The newly eligible member will be enrolled in the same health plan as the Medicare members on their health insurance. They will receive ID cards from their new health plan, and coverage will be effective on their Medicare effective date. Any non-Medicare members will stay on the non-Medicare health plan.

Life Change Event Documentation Requirements *Documentation required/must be submitted to ETF.

Reason for Change or Enrollment	Type of Documentation
*Adoption	Recorded copy of court order granting adoption or letter of placement for adoption.
*Cancel coverage/remove adult dependent due to enrollment in other health insurance coverage	Copy of medical ID card or letter from health plan indicating effective date of other coverage. Must be received within 30 days of enrollment in other coverage.
*Death	Original death certificate.
*Disabled, age 26+	Copy of letter from health plan approving disabled status.
*Divorce (Family coverage remains in place when dependents other than spouse/stepchildren covered.)	Copy of *Continuation-Conversion Notice* (ET-2311) sent to ex-spouse of the subscriber. (ETF may request copy of divorce decree from clerk of courts showing date of entry of divorce if needed per the Terms and Conditions.)
*Eligible **and** enrolled in Medicare	Copy of Medicare card and *Medicare Eligibility Statement* (ET-4307). (**Note**: If you are on COBRA Continuation and the subscriber or dependents become Medicare eligible after the COBRA effective date, subscriber or dependent is no longer eligible to continue on COBRA.)
*Legal change of name (other than due to marriage or divorce)	Copy of court order.
*Legal ward	Court order (Letters of Guardianship) granting **permanent** guardianship of person.
*Loss of other coverage or loss of employer contribution to premiums (applies to participant and dependents)	The following items on letterhead from the previous insurer or former employer, dated and issued after termination of coverage. Materials providing prospective termination dates are not acceptable. 1. Who was covered (must list the name of the participant who is requesting this special, late enrollment) 2. Name of health insurer 3. Subscriber name 4. Date coverage was terminated 5. Reason for the cancellation (that is voluntary such as due to non-payment of premium vs. involuntary such as due to job loss). COBRA notice is acceptable if the coverage end date, covered individuals and health plan are indicated. If loss of employer premium contributions, letter from employer indicating they no longer contribute toward their employee's premium.
*National Medical Support Notice	Copy of National Medical Support Notice.
*Paternity	Court order declaring paternity, Voluntary Paternity Acknowledgement filed with DHS or birth certificate.
*Social Security number change	Copy of card or letter from Social Security Administration.
*State retiree re-enroll	*Sick Leave Re-enrollment Application* (ET-4317) and additional documentation listed on the sick leave re-enrollment application.
Birth	Birth certificate required for single parent. (ETF may request documentation for married couples per the Terms and Conditions.)
Change of address/telephone	No documents required but ETF may request per the Terms and Conditions.
Divorce (family to individual)	No documents required but ETF may request per the Terms and Conditions.
Marriage	ETF may request original or certified copy of marriage certificate per the Terms and Conditions.

Health Plan Contact Information

Dean Health Insurance
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 Insurance-Prevea360 Health Plan
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: 1-866-333-2757
Website: www.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
840 Carolina Street
Sauk City, WI 53583-1374
Telephone: 1-844-644-3455
Fax: 608-643-2564
Website: ChooseQuartz.com

Robin with 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/etfrobin

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

WEA Trust
45 Nob Hill Road
Madison, WI 53703-3959
Telephone: 1-866-485-0630
Fax: 608-276-9119
Website: weatruststate.com

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 from my employer, 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 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 Medicare Advantage plan and enrolled in the IYC 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 It's Your Choice 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 or sex.

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 crportal.hhs.gov/ocr/portal/lobby.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/office/file/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 hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. 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).

Arabic – ملاحظة: إذا كنت تتحدث اللغة العربية، فهناك خدمة مساعدة 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, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. 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 हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 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)