group health Cooperative of eau claire

Subscriber Application

Employer Name: _____ Group #: _____ Division #: ___ Policy Code: _____

Effective Date of Coverage: _____

Please select the type of coverage you are applying for: ☐ **Medical and/or** ☐ **Dental**

Who will be covered? ☐ Employee Only ☐ Employee & Spouse ☐ Employee & Child(ren) ☐ Family

Applicant Information

Last Name	First Name		Middle Initial
Street Address	City	State	Zip

Social Security No.	Date of Birth	Gender	Primary Care Clinic	Primary Care Physician	Height/Weight

Home Phone	Work Phone	Cell Phone

Are you (check all that apply):

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Retired

☐ COBRA — Start Date: _____ Term Date: _____ Reason: _____

☐ State Continuation — Start Date: _____ Term Date: _____ Reason: _____

Family Information

Last Name	First Name	MI	Social Security #	Date of Birth	Gender	Relationship	Height / Weight	Clinic/ Physician
					☐ M ☐ F		Ht:	C:
							Wt:	P:
					☐ M ☐ F		Ht:	C:
							Wt:	P:
					☐ M ☐ F		Ht:	C:
							Wt:	P:
					☐ M ☐ F		Ht:	C:
							Wt:	P:
					☐ M ☐ F		Ht:	C:
							Wt:	P:
					☐ M ☐ F		Ht:	C:
							Wt:	P:

Enrollment Reason

Check the box that applies:

- ☐ New Group Enrollee:
  Full-time employee as of what date: _____ Hours worked per week: _____
- ☐ New Hire (You must apply during your probationary period.) – Date of hire: _____
- ☐ Rehire – Date of hire: _____
- ☐ Open Enrollment
- ☐ Termination or exhaustion of other coverage – Effective date of coverage termination: _____
  You must include a copy of your certificate of creditable coverage from your prior carrier.
- ☐ Other (please explain): _____

Please turn over and complete back page.

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Other Insurance Information *(Please complete both sections.)*

Does anyone named in this application have other group insurance coverage? ☐ **Yes** ☐ **No**
If yes, who? _____

a. Type of Coverage: ☐ Medical ☐ Dental ☐ HIRSP
b. Individual's Employer: _____ Employer's Phone #: _____
c. Name under which policy is listed: _____ Social Security #: _____
d. Check one: ☐ Single Plan ☐ Family Plan Policy ID #: _____ Group #: _____
e. Effective Date: _____ Cancel Date: _____
f. Name of insurance company: _____
Address: _____

Is anyone named in this application eligible for Medicare coverage? ☐ **Yes** ☐ **No** **If Yes, complete the following:**
Reason: ☐ Age 65 or older ☐ Disability ☐ End Stage Renal Disease – onset date: _____
Name: _____ Medicare Card #: _____
Part A Effective Date: _____ Part B Effective Date: _____

Medical Information *(If applying for dental coverage only, skip this section.)*

If you are a new group enrollee, please complete this section. You do not need to complete this section if you are enrolling into an existing group plan.

1. Are you or any dependent now pregnant? ☐ Yes ☐ No
If yes, Name: _____ Due Date: _____
2. Have you or any dependents incurred health claims in excess of $10,000 over the last 5 years? ☐ Yes ☐ No
If yes, Name: _____ Date of Occurrence: _____
Conditions: _____
3. Are you or any dependent disabled or unable to perform normal activities? ☐ Yes ☐ No
If yes, Name: _____ Reason: _____
4. Do you or any dependents have any or had any scheduled hospitalizations, surgeries or tests? ☐ Yes ☐ No
If yes, Name: _____ Reason: _____
5. Are you or any dependents currently taking any medications? ☐ Yes ☐ No
If yes, list medications, dosages and what medical condition is being treated or were treated by each medication: _____

Add additional pages as needed and sign/date the additional pages.

I, the applicant, agree that:

1. The coverage available to me will be provided by Group Health Cooperative of Eau Claire. The company shall hereinafter be referred to as Insurer.
2. The answers I have given are true and complete to the best of my knowledge. My answers are the basis for any insurance issued.
3. I, and my dependents named in the application, will cooperate in providing the Insurer with information needed to process this application. By signing this application, I understand the Insurer will comply with Federal and Wisconsin State laws with regard to maintaining the confidentiality of my and my dependent(s) individually identifiable health information (IIHI) and may access IIHI for myself or named dependents as necessary for treatment, payment, and health care operations.
4. Coverage is in effect only after Insurer approves this application and I complete any probationary period required by my employer.
5. A photocopy of this authorization will be as effective and valid as the original.
6. If Insurer approves this application, I authorize my employer to deduct premiums I may be required to pay from my payroll.

I HEREBY APPLY FOR ENROLLMENT SUBJECT TO TERMS AND CONDITIONS:

Employee Signature: _____ Date Signed: _____

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Waiver of Coverage

I acknowledge that I have been offered the opportunity to apply for group coverage and decline to enroll as indicated on behalf of myself and/or my dependents.

I have decided not to apply for coverage offered for:

Medical:	☐ Employee	☐ Spouse	☐ Child(ren)
Dental:	☐ Employee	☐ Spouse	☐ Child(ren)

I decline enrollment at this time because:

- ☐ I and/or my dependents am/are covered or will be covered under another plan that is **not** sponsored by my employer. I am not enrolled for coverage under the Health Insurance Risk Sharing Program (HIRSP).
- ☐ I am covered by another plan that is sponsored by my employer.
- ☐ I am not enrolled in HIRSP and the annualized premium contribution to be paid by me on behalf of myself or my dependents would exceed 10% of my annualized gross earnings from this employer.
- ☐ Other:

If you are declining enrollment for yourself or dependents (including your spouse) because of other health care coverage, you may, under certain circumstances, in the future enroll yourself or your dependents in this plan prior to the next open enrollment period. You must request enrollment within 30 days after the other coverage ends. In addition, if you have new dependents as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents provided you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

Employee Signature: _____ Date Signed: _____