

CITY OF WEST ALLIS
HEALTH and STANDARD DENTAL INSURANCE APPLICATION



EMPL NO: _____ EFFECTIVE DATE: March 1, 2016 REASON: Open Enrollment

CHECK TYPE of COVERAGE YOU ARE APPLYING FOR:

HEALTH: PPO Health Plan
 HDHP (High Deductible Health Plan)
 I DECLINE/WAIVE coverage. **Note: If declining health coverage, a separate waiver must be completed. Form available from HR.**

Office Use Only

Group No: 004009947 Product: _____
Division: _____ Package Code: _____
Employee Status: A CWA Group: _____

DENTAL: **Standard Plan** (aka Anthem); **OR**
 CarePlus Plan (NOTE: completion of the Care Plus application form is required); **OR**
 I **DO NOT** wish to enroll in either Dental insurance plan

Office Use Only

Group No: _____ Subgroup: _____

CHECK LEVEL of COVERAGE YOU ARE APPLYING FOR:

Single (includes widow[er]/divorcee) Couple (Employee +1) Family (Employee + 2 or more)

PLEASE PRINT***PLEASE PRINT*****PLEASE PRINT**

Last Name _____ First Name _____ Middle Initial _____
 Social Security # _____ - _____ - _____ Date of Birth _____ / _____ / _____ Male Female
 Month Day Year
 Marital Status: Married Single (including widowed or divorced)

PRIMARY ADDRESS:

Street Address _____
 City _____ County _____ State _____ Zip _____
 New Address? No Yes; indicate date changed: _____

PRIMARY PHONE NUMBER: (_____) _____ - _____ New Phone Number? No Yes

YOU MUST COMPLETE ALL PORTIONS OF THIS SECTION FOR YOUR DEPENDENTS (SPOUSE AND/OR CHILDREN) IF APPLYING FOR COVERAGE OTHER THAN FOR YOURSELF.

Last Name	First Name	MI	Sex	Date of Birth	Dependent	Social Security No.
			<input type="checkbox"/> M <input type="checkbox"/> F	____/____/____	<input type="checkbox"/> Spouse <input type="checkbox"/> Child	____-____-____
			<input type="checkbox"/> M <input type="checkbox"/> F	____/____/____	<input type="checkbox"/> Spouse <input type="checkbox"/> Child	____-____-____
			<input type="checkbox"/> M <input type="checkbox"/> F	____/____/____	<input type="checkbox"/> Spouse <input type="checkbox"/> Child	____-____-____
			<input type="checkbox"/> M <input type="checkbox"/> F	____/____/____	<input type="checkbox"/> Spouse <input type="checkbox"/> Child	____-____-____

IS ANYONE NAMED IN THIS APPLICATION COVERED BY ANOTHER GROUP HEALTH &/OR DENTAL PROGRAM?

NO YES - Complete the following:

Name of Policy Holder _____
 Name of Other Insurance Company _____ Account or Group No. _____
 Policy Holder's ID Number _____ Type of Coverage Single Family
 Identification Number _____ Health Dental
 Individuals Covered Under the Plan _____

YOU MUST COMPLETE ALL PORTIONS OF THIS SECTION FOR ANYONE IN THIS APPLICATION (including yourself) WHO IS COVERED BY MEDICARE, or MEDICAID, or TITLE 19.

Last Name: _____ Middle Initial _____ First Name _____

Medicare: Medicare Card Number: _____ Part A effective Date: ____/____/____
 Medicaid: Number: _____ Effective Date: ____/____/____
 Title 19: Number: _____ Effective Date: ____/____/____
 Part B effective Date: ____/____/____

Reason for Coverage: 65 or older Disabled Other: _____

Last Name: _____ Middle Initial _____ First Name _____

Medicare: Medicare Card Number: _____ Part A effective Date: ____/____/____
 Medicaid: Number: _____ Effective Date: ____/____/____
 Title 19: Number: _____ Effective Date: ____/____/____
 Part B effective Date: ____/____/____

Reason for Coverage: 65 or older Disabled Other: _____

TERMS AND CONDITIONS

1. To the best of my knowledge and belief, all statements and answers in this application are complete and true. I understand that if I provide false or fraudulent information on this application, I may face criminal charges/sanctions, reductions or denials of claims and/or other disciplinary action which may include termination of coverage under this plan.
2. I authorize the City of West Allis to obtain any information from any source necessary to administer this insurance.
3. I agree to pay the current premium for this insurance, and I authorize the City of West Allis to collect through payroll deduction or other arrangement as approved by Finance, an amount sufficient to provide for regular monthly premium payments.
4. As defined under 2011 Wisconsin Act 32, children may be covered on an employer's health and/or dental plan(s) to age 26. In addition, coverage may be provided to children age 26 and older if the following requirements are met:
 - The child is a full-time student; AND
 - The child was called to federal active duty in the National Guard or in a reserve component of the U.S. armed forces while the child was attending an institution of higher education on a full-time basis; AND
 - The child was under the age of 27 years when called to federal active duty; AND
 - The child applies for full-time student status at an institution of higher education up to 12 months after completing active duty; AND
 - If the child is called to active duty more than once within a four-year period of time, the child's age at the time of their first call to active duty will be used when determining eligibility under this Plan.

Children may also be covered beyond age 26 if they have a disability of long standing duration and all of the following exist:

 - Permanently mentally disabled or permanently physically handicapped; AND
 - Incapable of self-sustaining employment; AND
 - The child meets all of the qualifications of a dependent as determined by the U.S. Internal Revenue Service; AND
 - The child is unmarried.
5. I understand that it is my responsibility to notify the City of West Allis Human Resources Department within 30 days of a qualifying event (change) affecting my coverage, including but not limited to, a change in eligibility due to marriage, birth/adoption/legal placement of child, legal separation, death, divorce, Medicare/Medicaid/Title 19 eligibility, attaining Medicare age, child no longer satisfies dependent requirements, an address change, etc. 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/premiums paid in error. Upon request, I agree to provide any documentation that the City of West Allis deems necessary to substantiate my eligibility or that of my spouse/dependents.
6. In accordance with the Consolidated Omnibus Reconciliation Act (COBRA), and subject to the terms stated in your Summary Plan Description, CONTINUATION of medical and/or dental benefits may be available for you and/or your covered spouse/dependents. You will receive information regarding COBRA continuation coverage (including premium costs) upon your (and/or your spouse/dependents) termination of coverage under this plan.
7. I understand that if I am declining enrollment for myself or my spouse/dependents because of other health insurance coverage, I may be able to enroll myself and my spouse/dependents in this plan if I or my spouse/dependents suffer a hardship (such as loss of other coverage). However, I must request enrollment within 30 days of the other coverage end date and provide proof of loss and any required documentation necessary to join the plan.
8. I agree to abide by the terms of my benefit plan, as explained in any written materials I receive from the City of West Allis or its third party administrator (Anthem), including, without limitation, the benefit handbook.

DATE: _____ EMPLOYEE SIGNATURE: _____

Maintain a copy of this application for your records; a copy is considered as valid as the original.