

**CITY OF WEST ALLIS
HEALTH INSURANCE APPLICATION - RETIREE**



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

CHECK LEVEL OF COVERAGE APPLYING FOR: Single (includes widow[er]/divorcee) Couple (Retiree +1) Family

- PPO Health Plan
- HDHP (High Deductible Health Plan)
- I DO NOT wish to enroll in either health plan option offered through the City

Office Use Only

Group No: 004009947 **Product:** _____

Division: _____ **Package Code:** _____

Employee Status: _____ **CWA Retiree Group:** _____

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 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: ____/____/____

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: ____/____/____

Reason for Coverage: 65 or older Disabled Other: _____

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 PROGRAM?

NO YES - Complete the following:

Name of Policy Holder _____

Name of Other Insurance Company _____ Account or Group No. _____

Policy Holder's Identification Number _____ Type of Coverage Single Family

Individuals Covered Under the Plan _____

**HEALTH INSURANCE APPLICATION
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 ACH withdrawal 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 plan through the end of the month in which they turn 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 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 re-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. I further understand I may not be eligible for re-enrollment due to any City policy, procedure, ordinance, and/or union contract in place at the time of my retirement.
 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: _____ **RETIREE SIGNATURE:** _____

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