INSTRUCTIONS FOR COMPLETION OF GROUP SUBSCRIBER APPLICATION

Please take the time to fill out this application form completely so that you and your family will receive proper and timely coverage. **Group Health Cooperative of South Central Wisconsin (GHC-SCW) requires the receipt of this application within 30 days after becoming eligible for GHC-SCW coverage. If the application is not submitted to GHC-SCW within this period of time, you may be considered a late entrant and subject to a waiting period of 12 months.**

This application is a legal document, so it is important that you fill it out completely and correctly. An incomplete application will delay the application process and access to appointments and services. The following instructions will help you complete the form. (Do not fill out the Group Leader / GHC-SCW section of the form; it will be completed by your employer and GHC-SCW.)

Section 1 - Employee Information

Complete all blank spaces in this section. Include your home and work telephone numbers and your spouse's work telephone number. Please also include your e-mail address, if applicable.

Section 2 - Reason for Application

Box A - Check the box for Initial Application or Change of Status. If you check Change of Status, be sure to list the date the change becomes effective.

Box B - Complete this section if you are reporting a change to your current policy. **List only family members affected by this change in Section 4.** Be sure to complete Section 1 if the change is regarding marital status, name change or address change.

Section 3 - Application for Coverage

Complete this section only if your employer offers more than one benefit plan. If your employer offers more than one benefit plan, indicate your choice of benefit (check the appropriate box).

Section 4 - Enrollment Information

Check the box for the coverage desired.

In the spaces provided, print the name, relationship of dependent, social security number (optional), birth date, and sex for each family member for whom you are requesting coverage. If you are requesting coverage for more than five dependents, please indicate the additional dependents on a separate page.

HMO & POS Members: When choosing your health care coverage, it is very important to include the name of a Primary Care Provider (PCP) for each person to be covered. By doing so, GHC-SCW is able to meet specific quality standards set by the National Committee for Quality Assurance (NCQA) while providing you and your family with better service and care.

Please Note: If we find while processing your subscriber application that you did not select a Primary Care Provider (PCP) for yourself and/or your dependents, or that you selected a PCP who is not accepting new patients, GHC-SCW will assign you and/or your dependents to an available PCP based on your age, gender and mailing address. The assigned PCP will be shown on your ID card at the time of enrollment.

Section 5 - Additional Information

Complete this section for yourself and any eligible dependents listed on this application.

Section 6 - Other Coverage

Complete this information if anyone listed on this application is covered by any other health insurance or is Medicare entitled. (Completion of this section does not preclude you from being investigated for other coverage.)

Section 7 - Optional Information

Complete this section for yourself.

Section 8 - Signature

The application must be signed and dated by the Applicant.

Section 9 - Group Leader / GHC-SCW Section

Return to your employer for completion of the Group Leader Section.

To receive information about covered services or for questions regarding your application, call the GHC-SCW Marketing Department at (608) 251-3356 or (800) 605-4327 .

of South Central Wisconsin

P.O. Box 44971
Madison, WI 53744-4971

Group Health Cooperative of South Central Wisconsin

GROUP SUBSCRIBER APPLICATION HEALTH PLAN

GROUP#

1. EMPLOYEE INFORMATION

EMPLOYEE - LAST NAME	EMPLOYEE - FIRST NAME	M.I.

ADDRESS - NUMBER AND STREET	CITY	STATE	COUNTY	ZIP CODE

PHONE (H):	PHONE (W):	SPOUSE'S PHONE (W):	E-MAIL ADDRESS

MARITAL STATUS:
☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

DATE OF MARITAL STATUS OCCURRENCE

EMPLOYER/GROUP NAME	HRS./ WK	FULL-TIME DATE OF HIRE	PART-TIME DATE OF HIRE

☐ HOURLY
☐ SALARY

☐ UNION
☐ NON-UNION

PREVIOUS OR MAIDEN NAME (IF ANY)

2. REASON FOR APPLICATION

A. ☐ INITIAL APPLICATION ☐ CHANGE OF STATUS

REQUESTED DATE OF COVERAGE OR DATE OF CHANGE ____________________

B. IF CHANGE OF STATUS, CHECK APPROPRIATE BOX(ES):

☐ ADDING DEPENDENT TO COVERAGE - REASON____________________

☐ DROPPING DEPENDENT FROM COVERAGE - REASON ____________________

☐ TERMINATION OF COVERAGE - REASON____________________

☐ ANNUAL DUAL CHOICE - PRIOR INSURANCE CARRIER ____________________

☐ LOSS OF OTHER INSURANCE - (ATTACH CERTIFICATE OF CREDITABLE COVERAGE)____________________

☐ NAME CHANGE (COMPLETE SECTION 1) ____________________

☐ ADDRESS CHANGE (COMPLETE SECTION 1)____________________

☐ TRANSFER FROM OTHER GHC-SCW GROUP - (PRIOR GROUP NUMBER AND NAME)____________________

☐ TRANSFER TO COBRA / CONTINUATION - REASON ____________________

☐ OTHER CHANGE - SPECIFY____________________

3. APPLICATION FOR COVERAGE

☐ HMO ____________________ ☐ POS ☐ PPO ☐ OTHER

☐ CO-PAY ☐ DEDUCTIBLE $____________________

4. ENROLLMENT INFORMATION - If you are requesting coverage for more than 5 dependents, please indicate the additional dependents on a separate page.

COVERAGE DESIRED: ☐ EMPLOYEE ONLY ☐ EMPLOYEE AND SPOUSE ☐ EMPLOYEE AND DEPENDENT CHILD(REN) ☐ EMPLOYEE, SPOUSE AND DEPENDENT CHILD(REN)

LAST NAME, FIRST NAME, MIDDLE INITIAL	RELATIONSHIP TO EMPLOYEE	MARITAL STATUS	SOCIAL SECURITY # (Optional)	BIRTH DATE	SEX M /F	HEIGHT	WEIGHT	SELECT A PRIMARY CARE PROVIDER -**HMO & POS Plans Only-	STUDENT STATUS List College, Graduation Date and No. of Credits/Semester
	SELF		- -	/ /					
	SPOUSE		- -	/ /					
			- -	/ /					
			- -	/ /					
			- -	/ /					

HMO & POS Members Only: Please Note: If we find while processing your subscriber application that you did not select a Primary Care Provider (PCP) for yourself and/or your dependents, or that you selected a PCP who is not accepting new patients, GHC-SCW will assign you and/or your dependents to an available PCP based on your age, gender and mailing address. The assigned PCP will be shown on your ID card at the time of enrollment.

5. ADDITIONAL INFORMATION (REQUIRED)

1. IS ANYONE NAMED IN THIS APPLICATION NOW DISABLED, MENTALLY INCOMPETENT OR UNABLE TO PERFORM NORMAL WORK OR AGE-RELATED ACTIVITIES? ☐ YES ☐ NO
   IF YES, PLEASE IDENTIFY NAME(S), HEALTH CONDITION(S), DATE(S) OF DISABILITY AND NAME(S) AND ADDDRESS(ES) OF THE ATTENDING PHYSICIAN(S) ____________
   (PLEASE SUBMIT SUPPORTING DOCUMENTATION OF DISABILITY.)
2. DOES ANY PERSON LISTED ABOVE PERMANENTLY LIVE AT A DIFFERENT ADDRESS THAN THE ADDRESS LISTED IN SECTION 1?
   ☐ YES ☐ NO IF YES, LIST NAME/CITY/STATE ____________
3. (a) DO ANY OF THE DEPENDENTS LISTED IN SECTION 4 PROVIDE LESS THAN 50% OF THEIR OWN FINANCIAL SUPPORT? ☐ YES ☐ NO
   IF YES, NAME ____________
   (b) ARE ANY OF THE DEPENDENTS LISTED MARRIED? ☐ YES ☐ NO IF YES, NAME ____________
   (c) ARE ANY OF THE DEPENDENTS LISTED ELIGIBLE FOR HEALTH COVERAGE THROUGH ANOTHER EMPLOYER? ☐ YES ☐ NO
   IF YES, NAME ____________
4. HAVE YOU OR ANY LISTED DEPENDENT EVER BEEN AN ENROLLEE AT GHC-SCW? ☐ YES ☐ NO
   LIST ALL PREVIOUS NAME(S): ____________

6. OTHER COVERAGE

WHEN ENROLLED IN GROUP HEALTH COOPERATIVE OF SOUTH CENTRAL WISCONSIN (GHC-SCW), WILL ANYONE LISTED ON THIS APPLICATION BE COVERED BY ANY OTHER HEALTH INSURANCE? ☐ YES (COMPLETE THE FOLLOWING) ☐ NO
(PLEASE DO NOT LIST INSURANCE BEING REPLACED BY GHC-SCW)

HEALTH INSURANCE NAME	HEALTH INSURANCE PHONE

HEALTH INSURANCE ADDRESS	NAME OF POLICYHOLDER	POLICYHOLDERS DATE OF BIRTH

EFFECTIVE DATE OF POLICY	GROUP NUMBER AND PATIENT ID NUMBER	EMPLOYER NAME

IS ANYONE LISTED ON THIS APPLICATION ELIGIBLE FOR MEDICARE COVERAGE? ☐ YES ☐ NO	NAME OF PERSON ELIGIBLE FOR MEDICARE COVERAGE

REASON: ☐ ESRD ☐ OVER 65 ☐ DISABLED	PART A (HOSP.) EFFECTIVE DATE	PART B (MED.) EFFECTIVE DATE	PART D (MED.) EFFECTIVE DATE	MEDICARE NUMBER

7. OPTIONAL INFORMATION

GHC-SCW WOULD LIKE TO PROVIDE YOUR MEDICAL CARE IN YOUR LANGUAGE OF CHOICE.

WHAT IS YOUR LANGUAGE OF CHOICE? ____________

PLEASE SELECT ONE OF THE FOLLOWING RACE/ETHNICITY CATEGORIES THAT YOU FEEL BEST IDENTIFIES YOU.

☐ AMERICAN INDIAN OR ALASKAN NATIVE ☐ ASIAN ☐ BLACK OR AFRICAN AMERICAN ☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
☐ WHITE

ARE YOU HISPANIC/LATINO? ☐ YES ☐ NO ☐ I DECLINE TO ANSWER THIS QUESTION

8. SIGNATURE

BY MAKING THIS APPLICATION FOR ENROLLMENT IN GROUP HEALTH COOPERATIVE OF SOUTH CENTRAL WISCONSIN (GHC-SCW), I AGREE TO BE BOUND BY THE TERMS OF THE GROUP SERVICE AGREEMENT BETWEEN MY EMPLOYER GROUP AND GHC-SCW. I ALSO AUTHORIZE MY EMPLOYER TO MAKE PAYROLL DEDUCTIONS AS NECESSARY TO PAY FOR ANY PREMIUM FOR COVERAGE THAT I HAVE ELECTED. I AUTHORIZE ANY HEALTH CARE PROVIDER, INCLUDING PHYSICIANS, CLINICS, HOSPITALS, MEDICAL INFORMATION BUREAU, INC. OR OTHER INSTITUTIONS NAMED IN THE APPLICATION FOR INSURANCE OR WHO ATTENDS OR HAS ATTENDED ME, MY SPOUSE, OR ANY OF MY CHILDREN, AT ANY TIME, TO DISCLOSE TO GHC-SCW INFORMATION FROM ANY HEALTH CARE RECORD FOR A PERSON APPLYING UNDER THIS POLICY. I UNDERSTAND THIS COULD INCLUDE, BUT IS NOT LIMITED TO IDENTITY, MEDICAL HISTORY, DIAGNOSIS, PROGNOSIS, DATE OF TREATMENT, TREATMENT TEST RESULTS, AND SUMMARY REPORTS. I ALSO UNDERSTAND THAT THIS CONSENT IS REVOCABLE EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN IN RELIANCE THEREON, AND THAT CONSENT WILL REMAIN IN FORCE FOR TWO AND ONE-HALF YEARS IN ORDER TO EFFECTUATE THE PURPOSES FOR WHICH IT IS GIVEN. A PHOTO COPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL. I AUTHORIZE THAT ANY PAYMENTS BY OTHER HEALTH INSURANCE FOR SERVICES RECEIVED FROM GHC-SCW BE MADE DIRECTLY TO GHC-SCW. FURTHER, I ACKNOWLEDGE THAT ALL MEMBERS COVERED UNDER MY POLICY ALLOW GHC-SCW TO USE PERSONAL HEALTH INFORMATION FOR TREATMENT, COORDINATION OF CARE, QUALITY ASSESSMENT AND MEASUREMENT, INCLUDING MEMBER SURVEYS, ACCREDITATION, BILLING AND OTHER LEGITIMATE, APPROPRIATE PURPOSES OF THIS NATURE FOR THE PURPOSES OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS. I UNDERSTAND THAT WHEN GHC-SCW TRANSMITS PERSONAL HEALTH INFORMATION TO PEOPLE AND ORGANIZATIONS OUTSIDE OF GHC-SCW THEY MAY DO SO ELECTRONICALLY OR BY OTHER MEANS; AGGREGATED OR BLINDED DATA IS SUBMITTED IF PERSONAL IDENTIFICATION IS NOT REQUIRED FOR CONDUCTING GHC-SCW BUSINESS. TO THE BEST OF MY KNOWLEDGE, ALL STATEMENTS AND INFORMATION PROVIDED IN THIS APPLICATION ARE COMPLETE AND TRUE.

SIGNATURE____________ DATE____________

9. GROUP LEADER / GHC-SCW SECTION

REQUIRED TO BE COMPLETED BY GROUP LEADER

GROUP #	EFFECTIVE DATE OF CHANGE
GROUP LEADER TELEPHONE NUMBER	
GROUP LEADER SIGNATURE	DATE

GHC-SCW ADMINISTRATIVE USE

CONTRACT TYPE	DATE RECEIVED
TRANSACTION TYPE	

Mail to: P.O. Box 44971, Madison, WI 53744-4971 (608) 251-3356 FAX (608) 828-4856 Group Health Cooperative of South Central Wisconsin

EMPLOYER COPY