Medical College of Wisconsin Affiliated Hospitals

WPS – HEALTH INSURANCE ENROLLMENT INFORMATION

NEW Employees -- you will receive your ON LINE enrollment instructions as part of your New Employee Packets.

GRADUATING\TERMING Employees -- you will receive a COBRA packet about two weeks before you leave.

EXISTING Employees -- There is an **ANNUAL OPEN ENROLLMENT PERIOD** for Health insurance each late May\June for July 1st (changes will be effective as of July 1stthrough the next June 30th which is the plan year).

You can add, increase (single to family), waive or reduce (family to single) your enrollment each year **during the annual open enrollment period prior to July 1st**. If you make no changes, your election automatically renews for the next plan year.

The open enrollment forms to change your Health insurance enrollment must be completed, signed, and dated and received by the insurance companies prior to 7/1 (will be effective 7/1). There can be NO exceptions.

Mail Completed Enrollment Form to: **MCWAH, 8701 Watertown Plank Road, Milwaukee, WI 53226**

OR

FAX Completed Enrollment Form to: **MCWAH 1-414-955-6409**

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You need to have a *Qualifying Event* as outlined below in order to make a change to your Health Insurance Coverage outside of the annual open enrollment period.

You must *Complete, Sign and Date a new enrollment form within 30 days* of the date of the qualifying event or you will need to wait until the next annual enrollment period to make the change.*

Qualifying Events – ALL Enrollments and changes thereto are subject to underwriting by WPS. SEE: The Plan Certificate for the official Policy covering each of the following events.

a) **Marriage** → Within 30 days of marriage, you can add or change to Family Coverage. The effective date of the event and the effective date of the new coverage is the date of marriage. The enrollment change form must be signed on or after the marriage date.

b) **Add Newborn Child to Existing Family Coverage** → Coverage is provided from the time of the Child's birth. You can email your name + the Child's name, gender, and birth date to gme@mcw.edu within 30 days of the Child's birth.

c) **Changing from Single to Family Coverage due to a Newborn Child** → Under the existing Single Coverage, coverage is provided for the newborn from the moment of the Child's birth and for the next 60 days after birth. To extend coverage beyond the first 60 days, an enrollment form must be submitted to change to Family Coverage. The effective date of the event and the effective date of the new coverage is the date of birth. In order to make this change on a **pre-tax basis**, the enrollment change ***must be submitted within 30 days***.

d) **Changing from NO Coverage to Family Coverage due to a Newborn Child** → The new enrollment form must be submitted within 30 days of birth. The effective date of that event and the effective date of the new coverage is the date of birth.

e) **Adoption of a child** → Similar to the addition of a newborn child. Based upon when the child is placed for adoption and\or the date of the final court order granting adoption. Email gme@mcw.edu within 30 days of the event for additional information if this event applies to you.

f) **Adding a Dependant to Existing Single or Family Coverage due to Court Order** → Email gme@mcw.edu within 30 days of the event for additional information if this event applies to you.

g) **Housestaff, their Spouse, or Other Dependant Loses Coverage under other Creditable Prior Coverage** → If you (or a dependant) did not enroll in the MCWAH WPS Health Insurance Plan when you otherwise could have enrolled, because you (they) were covered by other creditable coverage at that time; you can enroll for Single or Family Coverage if you (they) lose that Coverage either voluntarily or involuntarily. You (they) must have been covered under creditable prior coverage at the time you otherwise could have enrolled. You must apply for the Single or Family Coverage within 30 days of the effective date of the loss of the prior coverage. [Example: **Spouse loses their coverage** (or you lose coverage under your Spouse's plan), voluntarily or involuntarily, under which you and\or your Family were covered at the time you could have initially enrolled in the MCWAH plan]. In order to make this change on a **pre-tax basis**, the loss of coverage generally needs to be due to *loss of eligibility* or *open enrollment at the spouse's employer*.

h) Housestaff, their Spouse, or Other Dependant Gain other Coverage under the spouse or dependent's employer's insurance plan due to a qualifying event → If you (or a dependant) gain other coverage by meeting the qualifying event requirements of their employer's plan (new hire, open enrollment, marriage, newborn, etc), you can cancel or reduce (Family to Single) that coverage by completing an enrollment change form within 30 days of the qualifying event (gain of other coverage). The change must be consistent with the corresponding gain in coverage with the other employer's plan.

i) **Divorce** → Within 30 days of divorce, you MUST complete an enrollment form to drop your former spouse from coverage as they will no longer be eligible. The effective date of the event and the effective date of the change in coverage is the 1st of the month following the date of divorce.

j) **Other Qualifying Events** → There may be other events that qualify for additions or changes in Health Insurance, such as a spouse moving into the country. A signed and dated enrollment form must be received within 30 days of the qualifying event date. Email gme@mcw.edu for additional information if you think you might have an event that would qualify.

NOTE

Premium Only Plan: Your signed enrollment form to enroll in the Health and\or Dental insurance is also an election to enroll in the Premium Only Plan (POP) with pre-tax deductions of your portion of the Health and Dental insurance premiums. **This election cannot be changed during the plan year (7/1-6/30) without a qualifying event** that is in compliance with both the insurance company plan certificate and the POP plan document. You must complete, sign, and date a new enrollment form within the time frame specified for the qualifying event (usually 30 days from the qualifying event date).

Your current election to the POP plan automatically renews each 7/1 if you do not actively change your enrollment with the Health and\or Dental insurance company prior to 7/1.

There is **an annual open enrollment period** each year prior to July 1st in which you can add, change, or waive your Health or Dental insurance enrollment (and your POP elections) without a qualifying event. **The open enrollment forms to change your Health or Dental insurance enrollment must be completed, signed, and dated and received by the insurance companies prior to 7/1 (will be effective 7/1).** There can be NO exceptions.

MEDICAL COLLEGE OF WISCONSIN AFFILIATED HOSPITALS

Availability of Summary of Benefits and Coverage (SBC) Health Insurance Plan Information

In accordance with the Patient Protection and Affordable Care Act [Health Care Reform Legislation], a **Summary of Benefits and Coverage (SBC)** is now available for our WPS Group Health Insurance plan.

The SBC follows a standardized template utilizing a uniform glossary of terms and can be used to compare this benefit plan to other benefit plans available to you.

The Summary of Benefits and Coverage includes summary information as to:

- Covered Health Benefits
- Prescription Drug Coverage
- Cost-Sharing (Deductibles, Copayments, Coinsurance, and Out of Pocket Costs)
- Limitations & Exceptions
- Coverage Examples
- And more

Note: Exact details and coverage are subject to the terms of the plan certificate.

The Summary of Benefits and Coverage (SBC) for the plan year:

Can be found on our website at any time directly at:
https://www.mcw.edu/-/media/MCW/Departments/Graduate-Medical-Education/sbc.pdf

The SBC is easily printable. Hard copies are available at no charge upon request to gme@mcw.edu or by calling WPS at 1-800-223-6048.

Signing this form to request coverage is also an election of pre-tax payroll deductions for the employee portion of the premiums.

WPS HEALTH INSURANCE®
1717 W. Broadway — P.O. 8190 — 53708-8190

Employee's Group Enrollment Application

Employer Information - This section to be completed by your employer.

Employer Name: MCWAH Employer Phone Number: _____

Group Number: **10006555**

Employee Instructions: Please print in black ink. Please fill out the entire application for anyone applying for coverage. Remember, as the **employee**, you must be applying for coverage for anyone else in the family to be eligible.

I. Reason For Application

Please indicate if you are:

- ❑ A new hire applying for: ❑ Single Coverage ❑ Family Coverage ❑ Waiving Coverage – Please also complete Section IV and VI.
- ❑ An employee who previously waived coverage and is applying due to:
  - ❑ loss of other coverage - date:_____ ❑ birth of a child ❑ adoption of a child ❑ marriage ❑ other: _____
- ❑ A late enrollee
- ❑ Applying for continued coverage under COBRA Start Date _____
- ❑ Adding a Dependent ❑ Deleting a Dependent Name:_____ Date: _____
- ❑ Canceling Coverage (Explain):_____
- ❑ Changing Coverage: From ❑ No Coverage ❑ Single Coverage ❑ Family Coverage To ❑ No Coverage ❑ Single Coverage ❑ Family Coverage Date_____

II. Employee Information

Social Security Number _____ Occupation Physician

Last Name_____ First Name _____ Middle Initial _____

Address _____ City_____ County _____ State _____ Zip _____

Daytime Phone _____ Evening Phone_____ E-mail Address _____

What is the first day you worked/rehired full-time with your current employer? _____

Are you: ❑ Single ❑ Married, Date Married_____ ❑ Divorced, Date Divorced_____ ❑ Widowed, Date Widowed_____

❑ On COBRA Continuation - Reason_____ Start Date_____ Termination Date _____

If you or any of your dependents are entirely waiving coverage, please fill out Section IV. and VII.

III. Applicant Enrollment Information

Complete the following for all family members, beginning with you the employee, who are applying for coverage. If additional space is needed please attach a separate sheet with completed information. If you are applying for coverage for your domestic partner, please attach the Declaration of Domestic Partnership.

	Last Name First Name Middle Initial	Gender / Student Status	Relationship
01	**EMPLOYEE Name:** _____ Date of Birth: ____/____/____	Gender: ❑ M ❑ F	
02	**SPOUSE or DOMESTIC PARTNER Name:** _____ Date of Birth: ____/____/____ Social Security #: _____	Gender: ❑ M ❑ F Domestic Partner ❑ Spouse ❑	
03	**Dependent Name:** _____ Date of Birth/Adoption: ____/____/____ Social Security #: _____	Gender: ❑ M ❑ F Full Time Student: ❑ Y ❑ N	❑ Child ❑ Stepchild ❑ Grandchild ❑ Domestic Partner's Child
04	**Dependent Name:** _____ Date of Birth/Adoption: ____/____/____ Social Security #: _____	Gender: ❑ M ❑ F Full Time Student: ❑ Y ❑ N	❑ Child ❑ Stepchild ❑ Grandchild ❑ Domestic Partner's Child
05	**Dependent Name:** _____ Date of Birth/Adoption: ____/____/____ Social Security #: _____	Gender: ❑ M ❑ F Full Time Student: ❑ Y ❑ N	❑ Child ❑ Stepchild ❑ Grandchild ❑ Domestic Partner's Child

IV. Coverage Options

Please check the coverage(s) you are applying for below. Availability of coverage(s) is based on your group's plan of insurance.
If anyone named in this application is waiving/declining coverage, please complete Section VI.

Coverage	Applying For		Waiving/Declining this Coverage For	
Group Medical Coverage	❑ Myself	❑ My Spouse	❑ Myself	❑ My Spouse
	❑ My Dependents	❑ My Domestic Partner	❑ My Dependents	❑ My Domestic Partner

V. Health Insurance and Medicare Information

A. Will anyone named on this application continue or maintain any other health or dental insurance or self-funded group medical plan in addition to the insurance being applied for today? ❑ Yes ❑ No

B. List all health coverage in the last 365 days (18 months for late enrollees). Failure to provide coverage information may result in a pre-existing condition limitation.

Name of Policyholder	Name and Address of Insurance Company / Plan	Type of Coverage (family or single)	Type of Plan (medical or dental)	Effective Date of Coverage	Cancellation Date
		❑ Family ❑ Single	❑ Medical ❑ Dental		
		❑ Family ❑ Single	❑ Medical ❑ Dental		

You have a right to request a certificate of creditable coverage from your prior plan. If necessary, we will assist you in obtaining a certificate from the prior plan.

If you received a certificate of creditable coverage from your prior plan, please attach a copy to this application.

C. Is anyone named on this application eligible for Medicare? ❑ Yes ❑ No If yes, please complete the following or attach a copy of your Medicare card.

Name of person covered by Medicare:_____ Medicare Claim Number: _____

Is Medicare eligibility due to: ❑ Over age 65 ❑ End-Stage Renal Disease (ESRD) ❑ Total disability

Part A Effective Date:_____ Part B Effective Date:_____ Part C Effective Date: _____

VI. Waiver of Coverage

If anyone named on this application is waiving or declining any coverage, please provide his/her name and check the reason he/she is waiving/declining:

Name(s) of person(s) waiving/declining:_____

❑ I am covered or will be covered under another plan that is not sponsored by my employer. I am not enrolled for coverage under Health Insurance Risk Sharing Program (HIRSP)

❑ My dependents are covered or will be covered under another plan that is not sponsored by my employer. My dependents are not enrolled for coverage under Health Insurance Risk Sharing Program (HIRSP), Forward or Badger Care.

❑ Other: _____

Waiver: I certify that I have been given the opportunity to apply for group coverage and decline to enroll as indicated on behalf of myself and/or my dependents. I understand that by signing this waiver, I and/or my dependents forfeit the right to coverage. If in the future I apply for coverage I or any of my dependents may be subject to exclusion of coverage for pre-existing conditions for a period of 18 months. This period may be offset by time covered under creditable coverage.

I understand that if I am declining enrollment for myself or my dependents (including my spouse) because of other health coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that I request enrollment within 31 days after my coverage ends. In addition, if I have a new dependent as a result of marriage, birth, adoption or placement for adoption, I understand that I may be able to enroll myself and my dependents provided that I request enrollment within 31 days after the marriage, birth or adoption. Any pre-existing waiting period that is in my policy will be offset by time served in a qualified plan.

Signature of Employee _____ **Date Signed** _____

VII. Notice of Special Enrollment Rights for Health Coverage

If you are declining enrollment for yourself or your dependents (including your spouse or domestic partner) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose coverage (or if the employer stopped contributing towards your or your dependent's other coverage).

Loss of coverage events include, but are not limited to: (a) the person no longer lives, resides or works within his or her HMO service area, the HMO does not provide coverage for that reason and there is no other coverage under the plan for the individual; (b) a dependent loses dependent status because he or she attains a particular age; (c) the plan no longer offers any benefits to a class of similarly-situated individuals (such as if the plan terminates coverage for all part-time workers); and (d) a benefit package option terminates or the issuer stops operating in the group market. In addition, if a claim is denied because a person has reached a lifetime limit on benefits, Health Insurance Portability and Accountability Act (HIPAA) regulations deem that to be a loss of eligibility for coverage for special enrollment purposes.

However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact:

MEMBER SERVICES DEPARTMENT
SUPERVISOR ADMINISTRATIVE OPERATIONS
TELEPHONE NUMBER: 1-800-748-0575

This Notice is for informational purposes only and is informing you of your special enrollment rights.

VIII. Applying for Coverage

I am requesting the coverage(s) I have selected in Section IV. above under the group policy(ies) issued by, or which may be issued by, WPS/EPIC/Delta Dental ("the Insurer"), and I authorize my employer to deduct any required contribution to pay for the coverage(s) from my earnings.

CERTIFICATION: I represent and certify all of the following: • I am employed by the employer named herein and am working the number of hours indicated on the front of this application; • I have read and completed this entire application by myself, and that no other person, including the agent, completed any portion of this application; • I entered each and every answer myself in response to each request for information and/or question; • no answer or information written by myself in this application was provided by the agent or anyone else (except for information provided by other family members); • such representations are true, accurate, and complete to the best of my knowledge; • I and my spouse and dependent(s) have been given the opportunity to apply for the coverage(s) available to me (us) through my employer; • and I was not pressured nor forced by my employer, the agent or the Insurer into waiving/declining any coverage as shown in Section VII. above.

UNDERSTANDING: I understand: • the representations I make, together with any supplemental representations that I make, shall be the basis for the Insurer to issue any coverage; • that no agent has the authority to waive an answer to any question, pass on insurability, make or alter any contract, or waive or alter any of the Insurer's other rights or requirements; • that no coverage will be effective unless and until the date specified by the Insurer after this application has been approved by the Insurer; • any misrepresentation contained herein may be used to reduce or deny a claim, void coverage, or void the group contract(s) within the contestable period, if such misrepresentation materially affects the Insurer's acceptance of the risk; including approving any person for coverage; • if my death occurs before EPIC has approved in writing any EPIC coverage, the only death benefit provided shall be the lesser of the maximum amount available without evidence of insurability or the maximum amount I am eligible for, under the coverage(s) for which I was eligible.

I understand that the Insurer has no liability for anything the agent said or failed to say before, during, or after the application process, that's not subsequently confirmed in writing by an authorized officer of the Insurer; including, but not limited to, answers given by the agent in response to questions asked by myself, my spouse or my dependent(s). Furthermore, I understand that the Insurer is not liable for any statement, representation, or other information provided to myself, my spouse or my dependent(s) that isn't expressly contained in a written document provided to them and signed by an authorized officer of the Insurer.

I understand and acknowledge that any person who, with intent to defraud or knowledge that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false and deceptive statement is committing a fraudulent act, which is a crime. I further understand and acknowledge that in some states, any person who, for the purpose of misleading an insurer or other person, conceals significant information from an application or claim is committing a fraudulent act.

AUTHORIZATION TO RELEASE MEDICAL RECORDS: I hereby authorize any licensed physician, medical practitioner, health care provider, hospital, clinic, or other medical or medically related facility, insurance or reinsuring company, Medical Information Bureau, Inc. ("MIB"), consumer reporting agency, or other organization, institution, or person that has any record or knowledge of me or my minor children to give to the Insurer or its legal representative, reinsurers, authorized agents or designees, any and all information (including information that constitutes protected health information as defined in the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA Privacy Regulations"), but excluding psychotherapy notes, if any) in any form, including, but not limited to, in original, electronic, or photographic copies, about me or my minor children to be covered concerning diagnosis, treatment and prognosis for any physical or mental condition, history or character, general reputation, personal traits, and mode of living, including, but not limited to, all medical and health care records. The information authorized for release shall not include whether the individual has obtained a test for the presence of HIV, antigen or nonantigenic products of HIV or an antibody to HIV or the results of such a test, if obtained by the individual.

I understand the information obtained by this authorization will be used by the Insurer to determine eligibility for coverage under my employer's group policy(ies) and that my failure to authorize the release of said information may result in a refusal to issue or provide coverage. I agree that the Insurer may release said information to MIB or to the Insurer's reinsuring companies, representative(s) or other person(s) performing business or legal services in connection with this application or as may be permitted or required by law, or as I may further authorize from time to time.

I understand I may revoke this authorization by providing advance written notice of termination to WPS at its office in Madison, Wisconsin, and that any information released in reliance on this authorization and prior to such revocation cannot be retrieved. In such case, WPS, its directors, officers, employees and agents shall not be held responsible or liable for such release. I understand this authorization will remain valid for 30 months from the date I execute this authorization unless this authorization is revoked by me in writing prior to the end of that 30-month period.

I understand that I am entitled to receive a copy of this completed, signed authorization, and that a photographic copy shall be as valid as the original. I understand that once information is disclosed pursuant to this authorization, it may no longer be protected by the HIPAA privacy Regulations and could be re-disclosed by the person or entity that receives it.

Has any person assisted you in the completion of this form? ❑ Yes ❑ No If yes, please print name: _____

Applicant's Signature _____ **Date Signed** _____