

Medical
Wisconsin Physicians
Service Insurance
Corporation
Policy Number
10000011

Dental
Delta Dental

Policy Number
91408

Vision
National Guardian Life
Insurance Company

Policy Number
NVA18187

Life/AD&D/STD/LTD/Dependent Life
The Lincoln National Life Insurance
Company

Policy Number
10080000 (Life and AD&D)
10080002 (LTD)
10080001 (STD)

EMPLOYEE ENROLLMENT FORM

Wisconsin Bankers Association Insurance Trust

Please complete this form if you are enrolling in a coverage you do not currently have.

| | | | | |
|---|---------------------------|---------------------------|------------------|--------------------------|
| Please Print Employer please complete the shaded area | Requested Effective Date: | Annual Salary \$ _____ | | |
| Billing # | | Dept. # | Employer Contact | |
| Employer Name | | City | | Employer Phone () |

| A. EMPLOYEE INFORMATION | | | | | |
|---|--|--|---|---|-------|
| Last Name | First Name | Initial | Social Security Number | | |
| Street Address | | City | | State | Zip |
| Home Phone | <input type="checkbox"/> Male <input type="checkbox"/> Female | Date of Birth | <input type="checkbox"/> Single <input type="checkbox"/> Married | <input type="checkbox"/> Divorced <input type="checkbox"/> Widow(er) | |
| Date First Worked: Full Time ___/___/___ Part Time ___/___/___ | # Scheduled Hours Per Week _____ | Are you actively at work? <input type="checkbox"/> Yes <input type="checkbox"/> No | Status: <input type="checkbox"/> Active <input type="checkbox"/> Retiree <input type="checkbox"/> COBRA | <input type="checkbox"/> Rehire <input type="checkbox"/> Return from leave | Date: |
| Job Title: | | | | | |

| B. DEPENDENT INFORMATION: COMPLETE FOR ALL DEPENDENTS WHO ARE APPLYING FOR COVERAGE | | | | | | |
|--|------------|---------|-----|----------------|---|----------------------------|
| Last Name | First Name | Initial | Sex | Birth Date | Full-Time Student | SSN# _____ - _____ - _____ |
| Spouse | | | | | | |
| DEPENDENTS | | | | ____-____-____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | SSN# _____ - _____ - _____ |
| | | | | ____-____-____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | SSN# _____ - _____ - _____ |
| | | | | ____-____-____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | SSN# _____ - _____ - _____ |
| | | | | ____-____-____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | SSN# _____ - _____ - _____ |
| Do all people covered under this insurance reside at the same location? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | |
| If no, please indicate the individual's name, the city in which they live and phone number. | | | | | | |

| C. CHECK THE TYPES OF COVERAGES YOU ARE APPLYING FOR | | | | | |
|--|--|--|--|---|--|
| MEDICAL: | <input type="checkbox"/> Employee Only | <input type="checkbox"/> Employee & Children | <input type="checkbox"/> Employee & Spouse | <input type="checkbox"/> Employee, Spouse, & Children | |
| DENTAL: | <input type="checkbox"/> Employee Only | <input type="checkbox"/> Employee & Children | <input type="checkbox"/> Employee & Spouse | <input type="checkbox"/> Employee, Spouse, & Children | |
| VISION: | <input type="checkbox"/> Employee Only | <input type="checkbox"/> Employee & Children | <input type="checkbox"/> Employee & Spouse | <input type="checkbox"/> Employee, Spouse, & Children | |
| Enroll | <input type="checkbox"/> Life & AD&D | <input type="checkbox"/> Dep. Life | <input type="checkbox"/> STD | <input type="checkbox"/> LTD | |
| Beneficiary | | | | | |
| Last Name | First | Initial | Relationship | % to each | |
| | | | | | |

D. ENROLLMENT STATUS

I am applying as a

- New Hire**
(You must apply during your probationary period)
- Late Applicant**
Late medical applicants are normally subject to a pre-existing condition limitation period. Late dental applicants are subject to benefit restrictions. Vision plans do not allow for enrollment as a late applicant. Late applicants for Life and AD&D, Dependent Life, Long and Short Term Disability are subject to Evidence of Insurability. Please refer to the terms and conditions in the plan booklet or check with your employer.
- Special Enrollment Period (Some plans do not allow for a special enrollment period, please check with your employer.)**
 - Birth
 - Adoption
 - Marriage
 - Termination or exhaustion of coverage (i.e. divorce, death of spouse)
 - Other (Please explain) _____

E. COMPLETE IF YOU HAVE OTHER INSURANCE, ARE MEDICARE ELIGIBLE OR HAVE EXISTING WPS COVERAGE.

| | | | | |
|--|----------------------------|---|--|--|
| 1) Does anyone named in this application have other group insurance coverage, or have existing WPS coverage? | | <input type="checkbox"/> Yes (Complete 1a-i, 2 & 3) <input type="checkbox"/> No (Complete 2 & 3) | 1a) Type of Coverage <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision | |
| 1b) Individual's Employer | | Employer Phone | | |
| 1c) Name under which policy is listed | 1d) Social Security Number | 1e) <input type="checkbox"/> Single Plan <input type="checkbox"/> Family Plan | 1f) Effective Date | |
| 1g) Name of Insurance Company, City (mailing address for claims), State, Phone Number | | 1h) Policy I.D. No. | 1i) Group No. | |
| 2) Do you or your spouse have dependent children from a previous marriage? | | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| 3) Is anyone named in this application eligible for Medicare coverage? | | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Name of Person | | | | |
| 3a) Reason <input type="checkbox"/> Over 65 <input type="checkbox"/> Disabled | | 3b) Medicare Card No. | | |
| 3c) Part A (Hosp.) Effective Date | | 3d) Part B (Med.) Effective Date | | |

F. TERMS AND CONDITIONS

1. The availability of any coverage to the Applicant and/or spouse is determined by the Employer’s inclusion of that coverage in the Group’s plan of insurance. The coverages, if so included, are provided by the following companies: Wisconsin Physicians Service Insurance Corporation (“WPS”), National Guardian Life Insurance Company; Delta Dental; and The Lincoln National Life Insurance Company. Such companies shall hereinafter be referred to as “Insurer(s)”.
2. All statements are true and complete and answers in this form are representations made by the Applicant on behalf of himself/herself and the dependents, if any, named herein to induce the issuance of the contract(s) applied for. The contents of this form are to be solely relied upon by the Insurer(s) exclusive of the knowledge of an agent or employee of the Insurer(s).
3. The Applicant and/or spouse on behalf of himself/herself and the dependents, if any, named herein, agrees to cooperate in providing the Insurer(s) with information needed to process this form. This might include signing a form for the release by hospitals, doctors and other health care providers of pertinent health care records to the Medical Information Bureau, the Insurer(s) or their legal representatives.
4. No person except an officer of the Insurer(s) is authorized to vary or modify a contract.
5. Subject to the acceptance of this Application by the Insurer(s), the Applicant authorizes the Employer to deduct from the Applicant’s wage or salary his/her portion, if any, of the premium for the coverages applied for and to timely remit such portion to the party designated by the Insurer(s).
6. Coverage is in effect only after: (a) the Insurer(s) approve this enrollment form, and (b) I complete any probationary period required by my Employer.
7. The contract(s) applied for will become effective only upon the Applicant’s completion of the probationary period, if any, and acceptance of this Application by the Insurer(s)/Company(ies). The Insurer(s)/Company(ies) will notify the Applicant of his/her effective date and issue an identification card for medical, dental and vision coverages.
8. This Application, when approved, and any endorsement, amendment or rider hereto will be made part of the contract(s) applied for.

NOTICE: A PERSON MAY BE COMMITTING INSURANCE FRAUD, IF HE OR SHE SUBMITS AN APPLICATION OR CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT WITH INTENT TO DEFRAUD (OR KNOWING THAT HE OR SHE IS HELPING TO DEFRAUD) AN INSURANCE COMPANY.

| | | |
|------------------|-------------------------------------|-------------|
| SIGNATURE | Please print name here: _____ | |
| | <input checked="" type="checkbox"/> | |
| | Signature of Applicant | Date Signed |



Employer Should Review Completed Form and Send to:

Wisconsin Bankers Association Insurance Trust
P.O. Box 7697
Madison, WI 53707-7697
Telephone: 1-888-441-0600