Security Health Plan.

1515 North Saint Joseph Avenue
P.O. Box 8000
Marshfield, WI 54449-8000
1-800-472-2363 or 715-221-9555

FOR OFFICE USE ONLY

Pre-ex: ☐ Yes ☐ No
Entrant: ☐ New ☐ Late
Pre-ex months ____________
Eff. date ____________

Group Health Insurance Application

Employer name	Group number	☐ Hire date ______ ☐ Recall date ______	Work status: ☐ Actively working ☐ Retired (date) ______
Coverage desired: ☐ Single ☐ EE + 1 ☐ EE + child(ren) ☐ Family	Plan type: ☐ HDHP ☐ HMO ☐ POS ☐ Indemnity		☐ COBRA Start date ______ End date ______

Applicant information

Last name	First name	MI	Former last name	Social Security no.	Sex: ☐ M ☐ F	Date of birth ___/___/___	Member ID (office use only)
Residence – street address			City		State	ZIP	County
Mailing – street address			City		State	ZIP	County
Home phone no. ( )	Work phone no. ( )		Cell phone no. ( )	Email address			

For family plan, list all other persons to be included

Last Name	First Name	MI	Former Last Name	Relationship	Social Security No.	Sex M	Sex F	Date of Birth Mo	Day	Yr	Member ID (office use only)
				Spouse							
				☐ Child ☐ Other______ ☐ Stepchild ☐ Grandchild							
				☐ Child ☐ Other______ ☐ Stepchild ☐ Grandchild							
				☐ Child ☐ Other______ ☐ Stepchild ☐ Grandchild							
				☐ Child ☐ Other______ ☐ Stepchild ☐ Grandchild							
				☐ Child ☐ Other______ ☐ Stepchild ☐ Grandchild							

Please complete the following optional information so we can better serve you. Your answers will not affect your enrollment.

		Subscriber	Spouse	Dependent Name ______	Dependent Name ______	Dependent Name ______
Language	What is your preferred spoken language?	☐ English ☐ Specify______	☐ English ☐ Specify______	☐ English ☐ Specify______	☐ English ☐ Specify______	☐ English ☐ Specify______
Language	What is your preferred written language?	☐ English ☐ Specify______	☐ English ☐ Specify______	☐ English ☐ Specify______	☐ English ☐ Specify______	☐ English ☐ Specify______
Race/Ethnicity	What race are you?	☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or other Pacific Islander ☐ Specify______ ☐ Two or more races	☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or other Pacific Islander ☐ Specify______ ☐ Two or more races	☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or other Pacific Islander ☐ Specify______ ☐ Two or more races	☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or other Pacific Islander ☐ Specify______ ☐ Two or more races	☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or other Pacific Islander ☐ Specify______ ☐ Two or more races
Race/Ethnicity	What is your ethnic background?	☐ Hispanic/Latino ☐ Not Hispanic/Latino	☐ Hispanic/Latino ☐ Not Hispanic/Latino	☐ Hispanic/Latino ☐ Not Hispanic/Latino	☐ Hispanic/Latino ☐ Not Hispanic/Latino	☐ Hispanic/Latino ☐ Not Hispanic/Latino

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White & yellow: Security Health Plan Pink: Employer

Check the reason and indicate the date for requesting change in coverage (if applicable)

☐ Marriage: Date of marriage ________ ☐ Death: Name of deceased ________________ Date of death ________
☐ Divorce: Date of divorce ________ ☐ Other ________________________________
☐ Add dependent: Date added ________ Reason added ________________ Marital status (if over age 18) ______

Complete the following questions regarding other insurance information

Will this application for insurance (if accepted) replace coverage for anyone currently insured on an INDIVIDUAL Policy (not through an employer) through Security Health Plan: ☐ Yes ☐ No
If yes, please complete a Health Plan Change Form to cancel the INDIVIDUAL policy.

Is anyone named in this application currently enrolled in Medicare: ☐ Yes, name ________________ (complete below) ☐ No

Medicare claim no. ____________ Eff. date Part A (hosp.) ____________ Eff. date Part B (med.) ____________

Were you or any dependents covered under a health plan within the past 63 days: ☐ Yes ☐ No
If yes, attach documentation of the health plan name and dates of coverage (i.e. Certificate of Creditable Coverage is preferred)

Is anyone named in this application covered by any other GROUP health insurance program: ☐ Yes (complete below) ☐ No

If family policy, list names of family members covered ________________________________

Policyholder's name	Cert./Subscriber number	Policy group number	Policyholder's employer

Other insurance company name	Address	Phone number

Coverage: ☐ Single ☐ EE + 1 ☐ EE + child(ren) ☐ Family	Eff. date	Cancellation date

I agree that the above answers are true and complete to the best of my knowledge and are made to induce the issuance of and as part of the policy I am applying for. I apply for enrollment subject to the Terms and Conditions below.

Applicant's signature ________________________ Date ____________

Terms and conditions

1. All statements and answers in this application are representations made by the applicant on his/her own behalf and for the other persons named in this application to induce the issuance of the contract(s) applied for.
2. The applicant on behalf of himself/herself and for the other persons named in this application agree to provide information as needed to process this application, i.e. previous health insurance coverage. Time served through previous qualifying coverage under an employer-based plan or individual health insurance policy will be credited toward your waiting period if there is less than a 63-day lapse. To determine previous creditable coverage, you should provide us with a "certificate of coverage" from your prior plan(s). A pre-existing waiting period will be applied automatically until we receive your certificate of coverage.
3. Subject to acceptance of this application by Security Health Plan of Wisconsin, Inc., it is understood and agreed that each participant consents to furnish Security Health Plan of Wisconsin, Inc., with all such medical and surgical reports, records, and other information as requested to process claims. This might include signing a form for the release of information from hospitals, doctors, and other health care providers to Security Health Plan of Wisconsin, Inc.
4. Subject to the acceptance of this application by Security Health Plan of Wisconsin, Inc., the applicant authorizes the named group as his/her remitting agent to deduct from his/her wages or salary an amount equal to a) the existing subscription fees or b) the difference between the existing subscription fees and that contribution made by his/her employer.
5. Subject to acceptance of this application by Security Health Plan of Wisconsin, Inc., the applicant agrees to use the services of Security Health Plan participating clinics, hospitals and physicians, except for "out-of-area emergency care" or when referred to a non-participating physician, clinic or facility. Written referrals must be arranged through a participating physician and approved by the Health Plan Medical Director prior to the receipt of services. These requirements do not apply to members enrolled in an Indemnity coverage option.
6. This form is an application for coverage only. Regardless of any advance payment of premiums, the policy applied for will become effective only upon the acceptance of this application by Security Health Plan of Wisconsin, Inc., to be evidenced by the issuance of an identification card and booklet/certificate.

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