



EMPLOYEE APPLICATION FOR GROUP COVERAGE

Dean Health Plan, Inc. | Dean Health Insurance, Inc.
 P.O. Box 56099 Madison, WI 53705 | (608) 828-1301 | (800)279-1301

Dean Health Plan, Inc. (DHP)/Dean Health Insurance, Inc. (DHI) must receive Applications within 31 days of the eligibility date. If the Application is not completed in full, it will not be processed.

Please check one:	FOR EMPLOYER USE ONLY:	FOR DHP/DHI USE ONLY:				
<input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> TOP <input type="checkbox"/> Focus <input type="checkbox"/> Point of Service <input type="checkbox"/> Point of Enrollment	Group Number: _____ Effective Date: _____ Employer Name: _____	Seg Yes / No Area	Pre-ex Yes / No M/C	Cont. No. PCP	PB COB	Tier

A	Employee Name (Last, First Middle)	Part-Time Date of Hire: _____	Are you actively at work? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Mailing Address, City, State, ZIP	Full-Time Date of Hire: _____	<input type="checkbox"/> Hourly <input type="checkbox"/> Salary <input type="checkbox"/> Non-Union <input type="checkbox"/> Union
	Home Phone Number: _____	County	
Work Phone Number: _____	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed / Date of Occurrence: _____		Hours worked per week: _____

B	Please indicate reason for submitting application: (Check appropriate box)	Effective date of change: _____
	<input type="checkbox"/> New Hire <input type="checkbox"/> Loss of Other Coverage <input type="checkbox"/> Late Applicant <input type="checkbox"/> Rehire <input type="checkbox"/> Return From Layoff	<input type="checkbox"/> Annual Dual Choice <input type="checkbox"/> Transfer to Disability Segment <input type="checkbox"/> Transfer to Retiree Segment <input type="checkbox"/> Part-time to Full-time Employment <input type="checkbox"/> Election for Continuation

C	Last Name, First Name & Middle	Relationship to Employee	Social Security Number	Date of Birth	Sex	HMO/TOP/FOCUS PLANS-SELECT A PRIMARY CARE PROVIDER or CLINIC
		Self				
		Spouse				

D	1. When this Policy becomes effective, will you or any family members listed above be covered by another DHP/DHI policy or by any other health insurance policy? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please provide Name(s): _____ ► If your dependent's other health insurance is determined by a court order, please attach a copy (e.g., divorce decree). Insurance Company Name: _____ & Phone Number: _____ Policyholder's Employer: _____ & Policyholder's Birth date: _____
	2. When this policy becomes effective, will you or any family members listed above be covered by Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", Name(s): _____ Medicare Number(s): _____ Effective Dates for Part A: _____ and Part B: _____ Is Medicare eligibility due to: <input type="checkbox"/> Age 65 <input type="checkbox"/> End Stage Renal Disease <input type="checkbox"/> Disability
	3. FAILURE TO COMPLETE THIS SECTION MAY RESULT IN A PRE-EXISTING CONDITION LIMITATION Do you or any dependent(s) listed in section "C" currently have, or have had, any other health coverage within the past 63 days? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", you must provide your coverage history for the past 18 months. Additional proof of this coverage may be required at a later date.

Carrier Name & Phone Number	Policy Number	Covered Persons	Dates of Coverage

E	1. Are you or any family member listed above totally disabled and not able to perform any duties of his/her occupation or perform normal activities of a person of the same age and sex? <input type="checkbox"/> Yes <input type="checkbox"/> No If, "Yes", please provide the following: Name(s): _____
	2. Are the dependents listed above, age 26 or older, incapable of self-sustaining employment due to mental retardation or a physical condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please provide Name(s): _____ Medical Condition(s): _____
	3. I certify that the plan benefits have been explained to me and/or I am fully aware that benefits may be reduced if I, or an insured family member, fail(s) to follow any Application requirements of the plan. <input type="checkbox"/> Yes <input type="checkbox"/> No

F	I UNDERSTAND THAT I AM ELIGIBLE FOR MEDICAL COVERAGE THROUGH MY EMPLOYER. I DO NOT want medical coverage for the following people: <input type="checkbox"/> Myself <input type="checkbox"/> Spouse/Domestic Partner <input type="checkbox"/> Children/Elig. Dep.
	The reason I am declining coverage at this time is because I or my dependents have coverage provided through: <input type="checkbox"/> Other group plan through my employer <input type="checkbox"/> Spouse's group plan <input type="checkbox"/> Individual <input type="checkbox"/> Medicare <input type="checkbox"/> Group COBRA/Continuation <input type="checkbox"/> Medicaid <input type="checkbox"/> No other coverage

I understand and agree upon the terms/conditions listed on the reverse side. A copy of this application is to be considered as valid as the original. I hereby authorize, on behalf of myself and my dependents, DHP/DHI to obtain or release medical information as set forth on the reverse side of this application. I certify that the plan benefits have been explained to me and/or I am fully aware that benefits may be reduced if I or an insured family member fails to follow any applicable requirements of the plan.

Employee Signature _____ Date Signed: _____ / _____ / _____

TERMS AND CONDITIONS

1. By signing this Application, I understand and agree that: (a) all statements and answers I have given are complete and true to the best of my knowledge and belief; (b) the insurance I hereby apply for will be effective only when Dean Health Plan, Inc. (DHP)/Dean Health Insurance, Inc. (DHI) approves this Application. Evidence of such approval will be the issuance of ID Card(s), which will be delivered to the group or employee. The effective date will be the date shown on the I.D. card issued; (c) the Social Security numbers I have provided may be used for I.D. purposes; and (d) if me or my dependents health has changed from what is indicated on the Application prior to the effective date of coverage, I will notify DHP/DHI of the change immediately. Changes in medical history prior to the effective date of coverage, but not reported to DHP/DHI, will be considered misstatements. Any person who knowingly presents a false or fraudulent claim within the contestable period for payment of a loss or benefit or knowingly presents false information in an Application for insurance is guilty of a crime and may be subject to fines and/or imprisonment under Wis. Stat. 943.395. I further understand that, in the event of fraud or misrepresentation, this information may be used to reduce or deny a claim, void coverage, or void the group contracts within the contestable period, if such misrepresentation affects DHP/DHI's acceptance of risk.
2. By my signature on this application, I authorize: (a) Any physician, medical practitioner, hospital, clinic, medically related facility or other institution who provided treatment or service to me, my spouse or my minor child(ren) at any time, or their agent(s) (including billing service), having medical information which includes, but is not limited to, identification, medical history, diagnosis, prognosis, consultations, advice, treatments, services, dates of treatments and/or services, test results (excluding genetic tests and FDA-licensed blood tests for the presence of HIV, but including X-rays), summary reports, without limitation to period of treatment, diagnostic or therapeutic information, history or type of injury or illness (including pregnancy and treatment or service, if any, for mental or nervous conditions, alcohol abuse or drug abuse), and (b) Any insurance or reinsuring company, service or prepaid benefit plan, plan administrator, consumer reporting agency, employer or personal or business associates having non-medical information about me, my spouse, or my minor child(ren), concerning eligibility and claim administration to disclose to DHP/DHI, or their representatives (including the claims department) all such information. I understand that when used for obtaining information in connection with an insurance policy application, this Authorization is valid for 30 months. I understand that when used for the purposes of obtaining information in connection with claims for benefits, utilization review, quality improvement, health care operations or other activities as permitted by law, this Authorization is valid during the Policy term or pendency of the claims for benefits, which ever is longer. I understand that I may request and receive a copy of this authorization.
3. I understand that any approved coverage is not effective for me or my dependents if I am not actively at work at my full-time employment with my employer on the assigned effective date, but that such coverage will first become effective on the first day thereafter that I am actively working at such employment.
4. This Application, when approved, and any endorsement, amendment, or rider thereto, will be made part of the contract(s) applied for.
5. No person, except an officer of DHP/DHI, is authorized to vary or modify a contract. I further understand and agree that DHP/DHI, its directors, officers, employees, and agents shall not be liable for any injury, damage, or expense (including attorney's fees) that I or any of my dependents suffer as a result of any improper advice, action, or omission on the part of any health care provider.
6. Subject to the acceptance of the Application by DHP/DHI, I authorize the group, as my remitting agent and until this authorization is revoked in writing, to deduct from my wages or salary a sufficient amount to provide for the regular and timely prepayment of the prevailing subscription fees that are not otherwise contributed by my employer for the contract(s) applied for and to remit the same on my behalf to DHP/DHI.
7. The contract(s) applied for will become void if and when I cease to be employed or affiliated with the group. Should I wish to retain my membership after such termination, it shall be my responsibility to secure a new application form from DHP/DHI and to apply for the programs then being offered to such individuals.