



## We've got you covered.

Thank you for your interest in our Individual Products. We offer a variety of plan designs to fit your specific health insurance needs. Enclosed is your policy application as well as information regarding plan options and membership benefits. **Please note the following important information regarding our Individual Products:**

**Eligibility** for our Individual Products is limited to U.S. citizens or resident legal aliens, ages 18 to 64, residing within the Dean Health Plan service area.

**Underwriting** may review the applicant(s) medical information. Please provide a daytime phone number on your application to minimize the review time.

**Plan Options and Riders** are available for you to select at the beginning of the application. Please select a plan option as well as any optional benefit riders you want covered.

Please be aware the online rate quotes are for illustrative purposes only. Final rates are determined based on the information you provide on the application. Dean Health Plan will notify you of the application decision and final rates, before you accept the policy.

### Checklist for enrolling in individual health insurance:

- ✓ **Policy Application** (completed, signed and sent to Dean Health Plan)
- ✓ **Authorization for Automatic Transfer of Funds** (required if your monthly premium will be paid through an automatic transfer from your bank account)
- ✓ **Premium Payment** (We require you to send in a personal check for your first month's premium with your application. You can obtain your premium using the online rating calculator at [www.deancare.com](http://www.deancare.com) or by calling Customer Care.)

Our Customer Care Center is here to help you. If you have any questions, please call (800) 279-1301 or TTY at (877) 733-6456. Customer Care hours are 7:30 a.m. - 5:00 p.m. Monday - Thursday and 8:00 a.m. - 4:30 p.m. Friday.

# ChamberOne PLAN APPLICATION

Dean Health Plan, Inc., 1277 Deming Way, Madison, WI 53717  
 (608) 828-1301 • 1-800-279-1301 • TTY (608) 827-4086 • www.deancare.com



Please complete this entire Application in ink.

**DHP USE ONLY:**

## PLAN/COVERAGE

- Plan:**                      **Coverage:**
- Dean Copay:              Copayment plan only; \$0/\$0 deductible, coinsurance and out-of-pocket
  - Dean 250:                \$250/\$500 deductible, 10% coinsurance, \$750/\$1,500 out-of-pocket
  - Dean 750:                \$750/\$1,500 deductible, 10% coinsurance, \$1,250/\$2,500 out-of-pocket
  - Dean 1250:               \$1,250/\$2,500 deductible, 20% coinsurance, \$2,250/\$4,500 out-of-pocket
  - Dean 1500:               (HSA Compatible) \$1,500/\$3,000 deductible, 20% coinsurance, \$2,500/\$5,000 out-of-pocket
  - Dean 3000:               (HSA Compatible) \$3,000/\$6,000 deductible, 0% coinsurance, \$3,000/\$6,000 out-of-pocket

**Optional Benefits:**    Prescription Drug Rider \$10/\$40/\$75

## MEMBER/DEPENDENT INFORMATION

**Please indicate the reason for submitting this Application:**

<input type="checkbox"/> New Applicant	<input type="checkbox"/> Birth/Adoption	<input type="checkbox"/> Rider/Policy change: _____
<input type="checkbox"/> Marriage	<input type="checkbox"/> Add/Delete dependents	<input type="checkbox"/> Name/Address/PCP change
		<input type="checkbox"/> Other: _____

**Applicant Name (Last, First, Middle):**

<b>Mailing Address</b>	<b>City</b>	<b>State</b>	<b>Zip</b>	<b>County</b>
------------------------	-------------	--------------	------------	---------------

<b>Home Phone</b>	<b>Work Phone</b>	<b>Name of Business:</b>
		<b>Number of Employees (including self):</b>
		<b>Name of Chamber:</b>
		<b>Date you became a Member of Chamber:</b>

**Marital Status:**    Single    Married    Divorced    Widowed   **Applicant/Spouse Maiden Name (if any)**

**Date of Status Change:**

**Effective Date:** Dean Health Plan, Inc (DHP) will assign the effective date of your Plan.

**COVERAGE DESIRED:**    Single    Family    Couple (Applicant/Spouse)    Limited Family (Applicant/Child(ren))

### COMPLETE THE FOLLOWING INFORMATION FOR ALL PERSONS APPLYING

NAME: Last, First & Middle	Relationship to Applicant	Sex	Birth Date	Social Security No.	Height/Weight
	Self				
	Spouse				

### COMPLETE THE FOLLOWING INFORMATION FOR ALL PERSONS APPLYING

Name	DHP Primary Care Clinic or Physician (PCP)	DHP USE ONLY
		PCP

<b>DHP USE ONLY</b>	Contract No.	Effective Date	Medicare	Tier	COB	Area
	Agent Code	Enrollment Entered Date:	UW Received Date:	UW <input type="checkbox"/> Approved   <input type="checkbox"/> Denied   <input type="checkbox"/> Closed Out Date:	UW Initials & Date	

**MEMBER/DEPENDENT INFORMATION *continued...***

**A. Are you or any family members applying currently disabled?** .....  Yes  No  
Name \_\_\_\_\_ Medical Condition \_\_\_\_\_

**B. Are you or any family members applying confined in a hospital?** .....  Yes  No  
Name \_\_\_\_\_ Medical Condition \_\_\_\_\_

**C. Do you or any family members applying have medical insurance in force or pending with any health insurance company?**  Yes  No Name(s) \_\_\_\_\_

Policyholder's Birth Date \_\_\_\_\_ Insurance Co. \_\_\_\_\_  
Insurance Co. Phone No. \_\_\_\_\_ Policy No. \_\_\_\_\_ Effective Date \_\_\_\_\_

**If your dependents' other health insurance is determined by a court order (e.g., divorce decree), please attach a copy.**

**D. Will your other health insurance cancel if the DHP policy is issued?** .....  Yes  No

**E. When this Policy becomes effective, will you or any family members applying be covered by Medicare?** .....  Yes  No

Name \_\_\_\_\_ Medicare No. \_\_\_\_\_

Name \_\_\_\_\_ Medicare No. \_\_\_\_\_

*Please enclose copies of business documents that provide proof that you are a sole proprietor/practitioner or that your business consists of only one employee.*

*During the Underwriting process the Chamber listed on Page 1 will be contacted to verify active membership and number of employees.*





**PREMIUM**

**Do not cancel any existing health insurance policy until receiving notification of approval from Dean Health Plan, Inc.**

Please indicate your choice of billing method (check one):

- Direct Billing Monthly:** You may prepay your monthly premium up to 12 months in advance.
- Automatic Transfer of Funds Monthly:** Please complete the Automatic Transfer of Funds authorization form enclosed with this Application.

**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, including my attestation that I am a current and valid member of the Chamber as listed; **(b)** the insurance I hereby apply for will be effective only when Dean Health Plan, Inc. (**DHP**) approves this Application. Evidence of such approval will be issuance of ID card(s) and information regarding how to obtain the policy. 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 my or my dependents health has changed from what is indicated on the Application prior to the effective date of coverage, I will notify DHP of the change immediately. Changes in medical history prior to the effective date of coverage, but not reported to DHP, will be considered misstatements. Any person who knowingly presents a false or fraudulent claim 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. Statute 943.395. I further understand that, in the event of fraud or misrepresentation, claims may be denied in whole, or in part, and coverage may be rescinded. I also understand and agree that I authorize any physician, medical practitioner, hospital, clinic, medically-related facility, or other institution that provides treatment or service to me, my spouse and dependents covered under this Application, to disclose any medical and service information to DHP or its representatives. All such information will be used for the purposes of quality assurance, quality improvement, utilization and medical management projects, studies and activities for the period of enrollment and coverage under this Application.
2. All statements and answers in this Application are representations made by me on behalf of myself and other persons named in the Application, if any, to induce the issuance of the contract(s) applied for. The contents of this Application are to be solely relied upon by DHP.
3. Health underwriting is required for all plan applicants and dependents. [Any health condition not disclosed on this Application or during the initial health underwriting that manifested itself through medical diagnosis or treatment in the twelve-month period prior to the enrollment date will be subject to a pre-existing condition limitation. Pre-existing conditions will be covered 24 months after the enrollment date.] DHP reserves the right, for two years following the original effective date, to retroactively void or rescind this policy if the Application misstated the health history or condition of any person(s) to be covered. The two year limitation does not apply to fraudulent misstatements made in the Application. . Coverage may be accepted or declined upon reapplication .
4. I, the undersigned, on behalf of myself and my dependents, if any, named in this Application, agree to cooperate in providing DHP with any information needed to process this Application.
5. This Application, when approved, and any endorsement, amendment or rider thereto, will be made part of the contract(s) applied for.
6. No person, except an officer of DHP, is authorized to vary or modify a contract. I understand and agree that DHP, 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.

\_\_\_\_\_  
**Applicant’s Signature**

\_\_\_\_\_  
**Date Signed**

\_\_\_\_\_  
**Spouse’s Signature**

\_\_\_\_\_  
**Date Signed**

## AUTHORIZATION

**By signing this form, I authorize** the disclosure and use of protected health information described below for pre-enrollment underwriting or risk-rating of health insurance coverage or to determine eligibility for enrollment or benefits under this health plan. This authorization is a condition of my enrollment in, or eligibility for, benefits under this health plan. If I decide not to sign this authorization, DHP may decline to enroll me in this health plan or provide me the benefits. I understand that once information is disclosed pursuant to this authorization, it may no longer be protected by the HIPAA Privacy Regulation and could be re-disclosed by the person or entity that receives it.

**When I sign below, I authorize any health care provider**, physician, medical practitioner, hospital, clinic, medically-related facility, or other institution, 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 disclose such information either in original or photographic copies, to DHP or its representatives (including, but not limited to, Claims, Medical Affairs, and Underwriting Departments).

This information 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, including without limitation, treatment, diagnostic, therapeutic information or history, regardless of type of injury or illness, including pregnancy and treatment or service, if any, for mental or nervous conditions (but not including psychotherapy notes), alcohol abuse, or drug abuse.

When I sign below, I authorize any insurance or reinsuring company, service or prepaid benefit plan, plan administrator, consumer reporting agency, employer, or personal or business associates having medical and non-medical information about me or my minor child(ren) to disclose to DHP, or its representative(s), (including, but not limited to, Claims, Medical Affairs, and Underwriting Departments) all such information, including photographic copies, thereof.

**I understand written notification is necessary to cancel this authorization.** To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact Customer Service. I am aware that my withdrawal will not be effective until received by DHP and will not be effective regarding the uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reliance on this authorization. I understand if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself. I understand this authorization will remain valid for two years from the date I, or my legal representative, execute this authorization. I further understand that I am entitled to receive a copy of this completed, signed authorization and that a photographic copy of this authorization is as valid as the original.

\_\_\_\_\_  
**Applicant’s Signature**

\_\_\_\_\_  
**Date Signed**

\_\_\_\_\_  
**Spouse’s Signature**

\_\_\_\_\_  
**Date Signed**

\_\_\_\_\_  
**Signature of Child Age 18 years old**

\_\_\_\_\_  
**Date Signed**

\_\_\_\_\_  
**Signature of Parent for child(ren)**

\_\_\_\_\_  
**Date Signed**

If this authorization is signed by a personal representative on behalf of an individual, please complete the following:

Personal Representative’s Name: \_\_\_\_\_

- Legal representative of minor
- Legal representative of incompetent
- Power of Attorney
- Other (please specify below): \_\_\_\_\_

**[AUTHORIZATION FOR AUTOMATIC TRANSFER OF FUNDS**

Dean Health Plan offers an easy way to make monthly premium payments, called the **Direct Premium Payment Program**. This service allows Dean Health Plan to automatically transfer funds from your checking or savings account on a monthly basis to pay your monthly premiums. This program ensures that your monthly premiums will be paid timely even if you are traveling and there is no cost to you for this service.

To participate, simply sign this authorization and attach a voided check or a personal bank deposit tickets that shows the bank and account number. Please be sure to fill in your financial institution name, routing number, and account number below. We will take care of the rest!

The Direct Premium Payment Program will start on the 23<sup>rd</sup> of the month following acceptance of your application. Automatic transfers from your bank account will occur on or around the 23<sup>rd</sup> of each month prior to the month of coverage. Any transfers that are not possible due to insufficient funds will be your responsibility.

If you have any questions, contact the Accounts Receivable Department at (608) 828-1301 or (800) 279-1301.

By signature below, I authorize Dean Health Plan to instruct my financial institution to deduct my premium payments from the account designated below. I authorize the financial institution to debit the amount of my premium from my designated account. This authorization is to remain in full force and in effect until Dean Health Plan has received written notification from the individual member of their termination in such time and in such manner as to afford Dean Health Plan and the financial institution a reasonable opportunity to act on it.

\_\_\_\_\_  Checking  Savings  
**Bank Name and Routing Number** **Account Number** **Type of Account**

*For Checking Accounts, please also attach a deposit slip or voided check from your account.*

\_\_\_\_\_ ]  
**Authorized Signature** **Date**