DANE COUNTY RETIREE HEALTH PLAN APPLICATION

Return to: DEAN HEALTH PLAN - ATTN: Enrollment
1277 Deming Way, Madison, WI 53717

PLEASE COMPLETE ALL AREAS IN INK

PLEASE CHECK ONE:
- ☐ Dean HMO
- ☐ Point of Service (POS)

FOR EMPLOYER USE ONLY

EFFECTIVE DATE

Employee Name (last, first, middle)	Department/Division	DATE OF HIRE FULL-TIME MO	DAY	YR	PART-TIME MO	DAY	YR
Mailing Address	Home Phone / Work Phone						
City, State, Zip	County / Are you actively at work? ☐Yes ☐ No	Hours worked per WEEK					

COVERAGE DESIRED: ☐ Single ☐ Family

MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Date of Occurrence

Maiden Name (if any)

COMPLETE FOR YOURSELF AND ALL FAMILY MEMBERS FOR WHOM YOU ARE SUBMITTING THIS APPLICATION

LAST NAME, FIRST NAME, MIDDLE	RELATIONSHIP TO EMPLOYEE	SEX M / F	SOCIAL SECURITY NUMBER	DATE OF BIRTH MO	DAY	YR	DISABLED	PRIMARY CLINIC SITE
	Employee		– –				☐ Y ☐ N	
	Spouse / Domestic Partner (circle one)		– –				☐ Y ☐ N	
			– –				☐ Y ☐ N	
			– –				☐ Y ☐ N	
			– –				☐ Y ☐ N	
			– –				☐ Y ☐ N	

A. TRANSFER/CHANGE IN COVERAGE: Complete this section to make any of the following types of changes or for a change in carrier during the annual choice period.

NAME OF PRESENT GROUP HEALTH INS.

GROUP OR FILE NUMBER

SUBSCRIBER NUMBER

- ☐ CHANGE TO FAMILY COVERAGE
- ☐ ADDING A DEPENDENT
- ☐ CHANGE TO SINGLE COVERAGE
- ☐ NEW ENROLLMENT
- ☐ OPEN ENROLLMENT
- ☐ ANNUAL CHOICE PERIOD CHANGE
- ☐ ADDRESS CHANGE
- ☐ DIVORCE (attach verification)
- ☐ NAME CHANGE (Former Name)_____
- ☐ OTHER (specify)_____

B. OTHER COVERAGE: Complete this section if you or anyone listed on this application are covered under other group health insurance.

GROUP NUMBER

SUBSCRIBER (POLICY) NO.

GROUP NAME

INSURANCE COMPANY

NAME OF INSURED

C. MEDICARE COVERAGE: Complete this section if anyone listed on this application is covered by Medicare.

SUBSCRIBER MEDICARE NO.

EFFECTIVE DATE (HOSPITAL) PART A

EFFECTIVE DATE (MEDICAL) PART B

NAME OF SPOUSE OR DEPENDENT COVERED

EFFECTIVE DATE (HOSPITAL) PART A

EFFECTIVE DATE (MEDICAL) PART B

ACCEPTANCE OF INSURANCE

I apply for the insurance under the indicated health insurance plan made available to me through the County of Dane and upon the terms and conditions listed on the reverse side. I am fully aware that benefits may be reduced if I or an insured family member fail to follow any applicable requirements of the plan. A copy of this application is to be considered as valid as the original.

SIGNATURE

DATE

☐ WAIVE COVERAGE

Sign below and ☒ box if you do NOT wish to enroll. See waiver on reverse side.

EMPLOYEE PRINT NAME

EMPLOYEE SIGNATURE

DATE

IMPORTANT NOTE: Applications must be received within 30 days from date of hire.

WHITE – CARRIER COPY

YELLOW –CONTROLLER

PINK – EMPLOYEE

TERMS & CONDITIONS

1. To the best of my knowledge, all statements and answers in this application are complete and true. 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 the county health insurance carrier, exclusive of the knowledge of an agent or employee of the county health insurance carrier.
2. The insurance I hereby apply for will be effective only when the county health insurance carrier approves this application. Evidence of such approval will be issuance of Identification Card(s) which will be delivered to the Group or the Applicant.
3. My remitting agent is Dane County.
4. I and my dependents are bound by the terms of the Health Services Agreement between Dane County and the county health insurance carrier. A copy of the Health Services Agreement is on file with Dane County and with the county health insurance carrier and either copy may be inspected during normal business hours upon request.
5. I agree to pay in advance the current premium for this insurance and I authorize the remitting agent to deduct from my wages or salary an amount sufficient to provide for regular premium payments that are not otherwise contributed. The remitting agent shall send the premium on my behalf to the insurance carrier I have selected.
6. I agree that any physician, hospital, or other institution, who attends or has attended me, my spouse, or any of my children is authorized to furnish the insurance carrier with any and all information including the history obtained, findings and diagnosis. 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, whichever is longer. I understand that I may request and receive a copy of this authorization.
7. I understand that any approved coverage is not effective if I'm not actively at work at Dane County 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.
8. This Application, when approved, and any endorsement, amendment, or rider thereto, will be made part of the contract(s) applied for.
9. No person, except an officer of the insurance provider, is authorized to vary or modify a contract. I further understand and agree that the insurance provider, 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.
10. 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.

EMPLOYEE'S REFUSAL OF HEALTH INSURANCE

I further certify that I fully understand that by this refusal I will not be entitled to any benefits whatsoever under such portion of the Group Insurance program, and that if I wish to become a participant in such portion of the Group Insurance program at a future date, I may be required to go through medical underwriting.