group health Cooperative of eau claire

Subscriber Application

Applicant Information

Last Name:	First Name:	Middle Initial:	Date of Birth:
Street Address:	City:	State:	ZIP:
Home Phone #:	Work Phone #:	Cell Phone #:	
Email Address:		Social Security #:	

Preferred Language:
☐ English ☐ Spanish ☐ Hmong ☐ Choose not to disclose ☐ Other (specify)

Are you: ☐ Single ☐ Married ☐ Divorced Effective Date of Change:

Are you on COBRA or State Continuation? ☐ Yes ☐ No
If Yes, Effective Date of Change and Reason:

Are you a retiree? ☐ Yes ☐ No

Sex Assigned at Birth:
☐ Male
☐ Female

Gender Identity:
☐ Male
☐ Female
☐ Trans male/Trans man
☐ Trans female/Trans woman
☐ Genderqueer, neither exclusively male nor female
☐ Other _____
☐ Choose not to disclose
☐ Unknown

Race/Ethnicity:
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White
☐ Asian
☐ American Indian or Alaska Native
☐ Hispanic or Latino
☐ Middle Eastern or North African
☐ Some other race, please specify:
☐ Unknown
☐ Choose not to disclose

Additional Information

This information will help us identify potential programs you/your dependents are eligible for.

1. Are you or any dependent now pregnant? ☐ Yes ☐ No
   If yes, Name: _____ Due Date:_____

2. List any chronic medical conditions you or your dependents have.

3. Are you or any dependents currently taking any medications? ☐ Yes ☐ No
   If yes, list medications, dosages and what medical condition is being treated or were treated by each medication:

Add additional pages as needed and sign/date the additional pages.

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Other Insurance Information

Does anyone named in this application have other group insurance coverage? ☐ Yes ☐ No

If yes, who?

a. Type of Coverage ☐ Medical ☐ Vision

b. Individual's Employer:_____ Employer's Phone #:_____

c. Name under which policy is listed:_____ Social Security #:_____

d. Check One: ☐ Single Plan ☐ Family Plan Policy ID #:_____ Group #:_____

e. Effective Date:_____ Cancel Date:_____

f. Name of Insurance Company:_____ Address:_____

Is anyone named in this application eligible for Medicare coverage? ☐ Yes ☐ No **If Yes, complete the following:**

Reason: ☐ Age 65 or older ☐ Disability ☐ End Stage Renal Disease – onset date:_____

Name:	Medicare #:	Part A Effective Date:	Part B Effective Date:
Part C Effective Date:	Part D Effective Date:		

Employer to Complete

Employer Name:

Effective Date of Coverage:	Plan ID:

Who will be covered? ☐ Employee Only ☐ Employee & Spouse ☐ Employee & Child(ren) ☐ Family

Enrollment Reason

Check the box that applies:

☐ **New Group Initial Enrollment**: Full-time employee as of what date:_____ Hours worked per week: _____

☐ **New Hire** (You must apply during your probationary period.) – Date of hire:_____

☐ **Open Enrollment:** Initial enrollment on Group plan during open enrollment period

☐ **Termination or exhaustion of other coverage** – Effective date of coverage termination: _____
You must include a copy of your certificate of creditable coverage from your prior carrier.

☐ **Other** (please explain): _____

I, the applicant, agree that:

1. The coverage available to me will be provided by Group Health Cooperative of Eau Claire. The company shall hereinafter be referred to as Insurer.
2. The answers I have given are true and complete to the best of my knowledge. My answers are the basis for any insurance issued.
3. I, and my dependents named in the application, will cooperate in providing the Insurer with information needed to process this application. By signing this application, I understand the Insurer will comply with Federal and Wisconsin State laws with regard to maintaining the confidentiality of my and my dependent(s) individually identifiable health information (IIHI) and may access IIHI for myself or named dependents as necessary for treatment, payment, and health care operations.
4. Coverage is in effect only after Insurer approves this application and I complete any probationary period required by my employer.
5. A photocopy of this authorization will be as effective and valid as the original.
6. If Insurer approves this application, I authorize my employer to deduct premiums I may be required to pay from my payroll.

I HEREBY APPLY FOR ENROLLMENT SUBJECT TO TERMS AND CONDITIONS:

Employee Signature:_____ Date Signed: _____

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Family Information

Name (Last, First, Middle):	Home Phone #:	Work Phone #:	Cell Phone #:

Email Address:	SSN:	DOB:

Relationship to employee:

Preferred Language: ☐ English ☐ Spanish ☐ Hmong ☐ Choose not to disclose ☐ Other (specify)

Sex Assigned at Birth:
- ☐ Male
- ☐ Female

Gender Identity:
- ☐ Male
- ☐ Female
- ☐ Trans male/Trans man
- ☐ Trans female/Trans woman
- ☐ Genderqueer, neither exclusively male nor female
- ☐ Other _____
- ☐ Choose not to disclose

Race/Ethnicity:
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Asian
- ☐ American Indian or Alaska Native
- ☐ Hispanic or Latino
- ☐ Middle Eastern or North African
- ☐ Some other race, please specify:
- ☐ Unknown
- ☐ Choose not to disclose

Does the dependent child(ren) named within this application live with you at the address shown above? If "no," please list the dependent child(ren)'s name and address(es): ☐ Yes ☐ No

_____

_____

Name (Last, First, Middle):	Home Phone #:	Work Phone #:	Cell Phone #:

Email Address:	SSN:	DOB:

Relationship to employee:

Preferred Language: ☐ English ☐ Spanish ☐ Hmong ☐ Choose not to disclose ☐ Other (specify)

Sex Assigned at Birth:
- ☐ Male
- ☐ Female
- ☐ Unknown
- ☐ Choose not to disclose

Gender Identity:
- ☐ Male
- ☐ Female
- ☐ Trans male/Trans man
- ☐ Trans female/Trans woman
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- ☐ Middle Eastern or North African
- ☐ Some other race, please specify:
- ☐ Unknown
- ☐ Choose not to disclose

Does the dependent child(ren) named within this application live with you at the address shown above? If "no," please list the dependent child(ren)'s name and address(es): ☐ Yes ☐ No

_____

_____

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Waiver of Coverage

I acknowledge that I have been offered the opportunity to apply for group coverage and decline to enroll as indicated on behalf of myself and/or my dependents.

I have decided not to apply for coverage offered for: **Medical:** ☐ Employee ☐ Spouse ☐ Child(ren)

I decline enrollment at this time because:

- ☐ I and/or my dependents am/are covered or will be covered under another plan that is not sponsored by my employer.
- ☐ I am covered by another plan that is sponsored by my employer.
- ☐ The annualized premium contribution to be paid by me on behalf of myself or my dependents would exceed 10% of my annualized gross earnings from this employer.
- ☐ Other: _____

If you are declining enrollment for yourself or dependents (including your spouse) because of other health care coverage, you may, under certain circumstances, in the future enroll yourself or your dependents in this plan prior to the next open enrollment period. You must request enrollment within 30 days after the other coverage ends. In addition, if you have new dependents as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents provided you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

Employee Signature:	Date Signed: