

IV. Applicant Enrollment Information

Complete the following for all family members, beginning with you the employee, who are applying for coverage. If additional space is needed, please attach a separate sheet with completed information.

	Social Security Number	Medicare Claim (HICN) Number	Gender/ Student Status	Primary Care Practitioner (PCP)
Employee Name (Last, First, MI)			<input type="radio"/> Male <input type="radio"/> Female	
Date of Birth				
Spouse Name (Last, First, MI)			<input type="radio"/> Male <input type="radio"/> Female	
Date of Birth				
Dependent Name (Last, First, MI)			<input type="radio"/> Male <input type="radio"/> Female	
Date of Birth <input type="radio"/> Child <input type="radio"/> Stepchild <input type="radio"/> Grandchild			Full Time Student <input type="radio"/> Yes <input type="radio"/> No	
Dependent Name (Last, First, MI)			<input type="radio"/> Male <input type="radio"/> Female	
Date of Birth <input type="radio"/> Child <input type="radio"/> Stepchild <input type="radio"/> Grandchild			Full Time Student <input type="radio"/> Yes <input type="radio"/> No	
Dependent Name (Last, First, MI)			<input type="radio"/> Male <input type="radio"/> Female	
Date of Birth <input type="radio"/> Child <input type="radio"/> Stepchild <input type="radio"/> Grandchild			Full Time Student <input type="radio"/> Yes <input type="radio"/> No	

Please complete the following information for those dependents over the age of 19 that are Full-Time Students.

Name: _____ School Attended: _____ Number of Credits: _____
 Address of School: _____ Anticipated Graduation Date: _____
 Is dependent on a medically necessary leave of absence from school? Yes No Date Last Attended: _____

Name: _____ School Attended: _____ Number of Credits: _____
 Address of School: _____ Anticipated Graduation Date: _____
 Is dependent on a medically necessary leave of absence from school? Yes No Date Last Attended: _____

V. Information About Other Medical Coverage

A. List all prior health or dental insurance coverage in the last 270 days (18 months for late enrollees). Failure to provide coverage information may result in a pre-existing condition limitation. Attach additional sheets if necessary.

Policyholder Information	Name, Address, & Phone Number of Insurance Company/Plan	Policy Number	Type of Coverage	Type of Plan	Effective Date of Coverage	Cancellation Date
Name: _____ <input type="radio"/> Employee <input type="radio"/> Spouse <input type="radio"/> Dependent Date of Birth: _____			<input type="radio"/> Family <input type="radio"/> Single	<input type="radio"/> Medical <input type="radio"/> Dental		
Name: _____ <input type="radio"/> Employee <input type="radio"/> Spouse <input type="radio"/> Dependent Date of Birth: _____			<input type="radio"/> Family <input type="radio"/> Single	<input type="radio"/> Medical <input type="radio"/> Dental		

B. Will you or any family member(s) continue or maintain any other health or dental insurance or self-funded group medical plan in addition to the insurance being applied for today? Please provide coverage information below. Attach additional sheets if necessary.

Policyholder Information	Name, Address, & Phone Number of Insurance Company/Plan	Policy Number	Type of Coverage	Type of Plan	Effective Date of Coverage	Cancellation Date
Name: _____ <input type="radio"/> Employee <input type="radio"/> Spouse <input type="radio"/> Dependent Date of Birth: _____			<input type="radio"/> Family <input type="radio"/> Single	<input type="radio"/> Medical <input type="radio"/> Dental		
Name: _____ <input type="radio"/> Employee <input type="radio"/> Spouse <input type="radio"/> Dependent Date of Birth: _____			<input type="radio"/> Family <input type="radio"/> Single	<input type="radio"/> Medical <input type="radio"/> Dental		

You have a right to request a certificate of creditable coverage from your prior plan, If necessary, we will assist you in obtaining a certificate from the prior plan. If you received a certificate of creditable coverage from your prior plan, please attach a copy.

C. Are you or any of your family members eligible for Medicare? Yes No

If yes, please complete the following or attach a copy of your Medicare card:

Name of Person covered by Medicare: _____ Medicare Claim Number: _____

Is Medicare eligibility due to: Age 65 End-Stage Renal Disease (ESRD) Total Disability

Effective Dates: Part A: _____ Part B: _____ Part C (Medicare Advantage): _____ Part D: _____

VI. Consent

If you or your dependents wish to authorize a representative to whom WPS Health Plan, Inc. may disclose personal health information to, please complete the attached consent form. The nature of the disclosures includes, but is not limited to, payment issues, benefit determination, and coverage of services. A separate consent form must be completed for each individual enrolled in the plan.

VII. Authorization

Authorization to release medical records: I hereby authorize any licensed physician, medical practitioner, health care provider, hospital, clinic, or other medical or medically related facility, insurance or reinsuring company, ("MIB, Inc."), consumer reporting agency, or other organization, institution, or person that has any record or knowledge of me or my minor children to give to WPS Health Plan, Inc. or its legal representative, reinsurers, authorized agents or designees, any and all information (including information that constitutes protected health information as defined in the privacy regulation promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996, as amended "HIPAA Privacy Regulation", but excluding psychotherapy notes, if any) in any form, including, but not limited to, in original, electronic, or photographic copies, about me or my minor children to be covered concerning diagnosis, treatment and prognosis for any physical or mental condition, history or character, general reputation, personal traits, and mode of living, including, but not limited to, all medical and health care records. The information authorized for release shall not include whether the individual has obtained a test for the presence of HIV, antigen or nonantigenic products of HIV or an antibody to HIV or the results of such a test, if obtained by the individual.

I understand the information obtained by this authorization will be used by WPS Health Plan, Inc. to determine eligibility for coverage under this policy and that my failure to authorize the release of said information might result in a refusal to issue or provide coverage. I agree that WPS Health Plan, Inc. may release said information to WPS Health Plan, Inc.'s reinsuring companies, representative(s) or other person(s) performing business or legal services in connection with this application or as may be permitted or required by law, or as I may further authorize from time to time.

I understand that I may revoke this authorization by providing advance written notice of termination to WPS Health Plan, Inc. at its office in Green Bay, Wisconsin, and that any information released in reliance upon this authorization and prior to such revocation cannot be retrieved. In such case, WPS Health Plan, Inc., its directors, officers, employees and agents shall not be held responsible or liable for such release. I understand this authorization will remain valid for 30 months from the date I execute this authorization unless revoked by me in writing prior to the end of that 30-month period.

I understand that I am entitled to receive a copy of this completed, signed authorization, and that a photographic copy shall be as valid as the original. 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.

EMPLOYEE SIGNATURE

GEN-EEF-0002
03-09

PRINT NAME

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DATE



We care for Wisconsin.

UNDERWRITTEN BY WPS HEALTH PLAN, INC.

CONSENT FORM

Arise Health Plan
P.O. Box 11625
Green Bay, WI 54307-1625
920-617-6330
Toll-free 1-888-711-1444 ext. 8330
Fax: 920-490-6928
BillingandEnrollment@wpsic.com

This form is used to obtain an individual's consent to allow a representative(s) of their choice to access the individual's protected health information for 30 months.

SECTION A: Individual Giving Consent.

Name: _____

Address: _____

Home Telephone: _____ Work Telephone: _____

Subscriber Number: _____ Social Security Number: _____

SECTION B: Consent - Please read the following statements carefully.

The following are representatives to whom I agree to permit WPS Health Plan, Inc. to disclose my protected health information. The nature of the disclosures includes but is not limited to payment issues, benefit determination, and coverage of services - unless restrictions are noted in Section C. I understand that WPS Health Plan, Inc. is not obligated to determine the legitimacy of a disclosure request made by a representative to whom I granted consent.

Representative: _____ Relationship: _____

Representative: _____ Relationship: _____

Representative: _____ Relationship: _____

SECTION C: Restrictions on Consent

You have the right to request that WPS Health Plan, Inc. restrict the nature of the disclosures made to the representatives you identified in Section B. Please indicate below any restrictions you make on these disclosures.

SECTION D: Right to Revoke

You have the right to revoke this consent at any time by giving us written notice of your revocation. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your written notice of revocation.

SECTION E: Signature

I have had full opportunity to read and consider the contents of this form. I understand that, by signing this form, I am giving my consent for WPS Health Plan, Inc. to disclosure my protected health information to the representatives identified above.

Printed Name: _____

Date: _____

Signature: _____