



WISCONSIN STATE EMPLOYEES GROUP ENROLLMENT FORM

Group Number 3180 Customer Number _____

P.O. Box 8430, Madison, WI 53708-8430

Section I Information about You

Address Change Complete Section I & V Enter your new address below.

LAST NAME		FIRST	MIDDLE	SOCIAL SECURITY NUMBER	
YOUR ADDRESS		NUMBER AND STREET		CITY	STATE ZIP
DATE OF BIRTH	GENDER <input type="checkbox"/> M <input type="checkbox"/> F		DATE OF EMPLOYMENT	HOME PHONE	WORK PHONE

Section II Reason for Submitting Application

- Initial Enrollment** Coverage to be Effective: 30 Days After 2 Months of WRS Coverage 6 Months (LTE Only)
Coverage Requested: You You + Spouse/Domestic Partner You + Child Family
- Special Enrollment** Coverage will be Effective: January 1, 2010
Coverage Requested: You + Domestic Partner You + Child* Family**
*You + One Child, age 18-26, inclusive. **You + Domestic Partner + his/her children, and/or children, ages 18-26, inclusive.
- Transfer between State Agencies** Complete Sections III, IV & V
- Spouse to Spouse Transfer** Transfer coverage from, Name: _____ SSN: _____
- Add Dependent** Date of Occurrence: _____ Complete Section III List only the dependent being added.
- Delete Dependent** Date of Occurrence: _____ Complete Section III List only the dependent being deleted.
- Cancellation** Complete Section V

Section III Information about Your Family PLEASE COMPLETE THIS SECTION FOR SPOUSE/DEPENDENT COVERAGE

List all Family Members to be Insured (First and Last Name) Select Add / Delete and Reason	Relationship To Employee	Member's SSN	Gender	Date of Birth	Federal Tax Dependent
<input type="checkbox"/> Add <input type="checkbox"/> Delete Reason:					
<input type="checkbox"/> Add <input type="checkbox"/> Delete Reason:					
<input type="checkbox"/> Add <input type="checkbox"/> Delete Reason:					
<input type="checkbox"/> Add <input type="checkbox"/> Delete Reason:					

Beneficiary Designation: Please complete the Beneficiary Designation Form found at www.epiclife.com

Section IV Information about Other Coverage

- A. I have the following group health insurance plans:
 State Standard Plan State HMO/PPO Plan
 Name of Primary Plan _____
- B. The following are covered under Medicare: Self Part A only Part A & B
 Spouse Part A only Part A & B
 Dependent Part A only Part A & B Name: _____
- C. If spouse is also employed, please complete the following:
Name and address of employer: _____
Name and telephone number of spouse's insurance carrier: _____
Spouse's group plan is: Health Individual Family Dental Individual Family Effective Date: _____

Section V I have answered the above to the best of my knowledge and belief. I understand EPIC is relying upon this information in determining my acceptance for coverage and that any misstatements or failure to provide sought for information may be used as the basis for rescission of my insurance.

Signature of Applicant			Date of Application			
OFFICE USE						

DATE RECEIVED BY GROUP/INITIALS GROUP NO. DEPARTMENT NO. EFFECTIVE DATE CLASS PREMIUM

E11444-0903