KADO & ASSOCIATES

Instructions for filling out application for Employer Sponsored Insurance Plan

1. Please fill out all the required fields on the following application. Only the fillable fields are needed for this application. All of the required sections are highlighted in red, as well as the areas that will need to be signed.

2. After you have completed the application, please print out and sign in the designated areas.

3. Upon your Human Resources' instruction, either hand the completed application to that person, or scan and email your application to awebbkadoins@wwt.net. You also have to option to fax your completed application to 715-235-0556 at Kado & Associates.

4. If you have any questions about the application or need help filling it out, please contact Amanda Webb at Kado & Associates and she will be happy to assist you.

718 NORTH BROADWAY • MENOMONIE, WI • 54751
PHONE: 715-235-8496 • FAX: 715-235-0556

Kado and Associates
718 N Broadway
Menomonie, WI 54751
715-235-8496
kadoinsurance.com

Waiver

Employee Name_____

SMALL EMPLOYER UNIFORM EMPLOYEE APPLICATION FOR GROUP HEALTH INSURANCE

Ref: Section Ins 8.49, Wis. Adm. Code, and Sections 601.41 (8), 635.10, Wis. Stat.

State of Wisconsin
Office of the Commissioner of Insurance
P.O. Box 7873
Madison, WI 53707-7873
(608) 266-3585
Web Address: oci.wi.gov

This form is designed for an employer's initial application for coverage. Please contact your agent or the insurer to determine if this form should be used in other situations once the group is enrolled with the insurer.

EMPLOYER INFORMATION – To be filled out by Employer

Employer Name _____ Group Number _____ Division Number _____
Employee Class _____
Total number of permanent employees who have a normal work week of 30 or more hours _____
Names of Insurers to whom information may be released:
Insurer: _____ Insurer: _____
Insurer: _____ Insurer: _____

I. EMPLOYEE INFORMATION

Employee Instructions: Please print using black or blue ink. Please fill out the entire application for each person for whom coverage is being sought.

Employee's First Name, Middle Initial and Last Name: _____
Social Security No.: _____ Birth Date: _____ Sex: _____ Height and Weight:_____
Street or Post Office Address: _____
City: _____ County:_____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Email: _____ ☐ Home ☐ Work

1. For your current employer: What was your first day of employment? ____/____/____
   How many hours, on average, do you work each week? _____
2. Are You:
   a) ☐ Single ☐ Married ☐ Legally Separated ☐ Divorced ☐ Widow or Widower
      If you are married, legally separated, divorced or widowed, please indicate the date that the event occurred: _____
      If you are married, please indicate the county and state, or country in which you were married: _____
      If you are married, please indicate your former or maiden name: _____
   b) A Retiree? ☐ Yes ☐ No
   c) On COBRA or State Continuation? ☐ Yes ☐ No
      If "Yes," provide start date and reason: _____

II. TYPE OF HEALTH COVERAGE

Please select the type of health insurance coverage for which you are applying:

[ ] Employee Only [ ] Employee and Spouse [ ] Employee and Dependent Child(ren) [ ] Employee, Spouse and Dependent Child(ren)

III. DEPENDENT INFORMATION

a) List all dependents, spouse and child(ren) applying for insurance. If you need additional space, please use a separate sheet of paper and attach it to this application (please sign and date the additional sheet).

Name (First; M.I.; Last)	Sex	Social Security Number	Relationship	Birth Date (Mo/Day/Yr)	Height Weight
			Spouse		
			[ ] Child [ ] Stepchild [ ] Grandchild [ ] Other _____		
			[ ] Child [ ] Stepchild [ ] Grandchild [ ] Other _____		

Employee Name_____

6. RESPIRATORY SYSTEM
a) allegry(ies) [ ] Yes [ ] No
b) asthma [ ] Yes [ ] No
c) emphysema [ ] Yes [ ] No
d) sinus or nasal disorder [ ] Yes [ ] No
e) lung disease or disorder [ ] Yes [ ] No
f) shortness of breath [ ] Yes [ ] No

7. NERVOUS SYSTEM
a) epilepsy or other seizures [ ] Yes [ ] No
b) headaches [ ] Yes [ ] No
c) multiple sclerosis [ ] Yes [ ] No

8. MUSCULAR or SKELETAL
a) arthritis [ ] Yes [ ] No
b) fibromyalgia [ ] Yes [ ] No
c) back disorder [ ] Yes [ ] No
d) joint disorder [ ] Yes [ ] No
e) musculoskeletal disorder [ ] Yes [ ] No
f) skin disorder [ ] Yes [ ] No
g) chronic fatigue syndrome [ ] Yes [ ] No

9. CANCER
a) cancer [ ] Yes [ ] No
b) tumor [ ] Yes [ ] No
c) abnormal growth [ ] Yes [ ] No
d) carcinoma in situ [ ] Yes [ ] No

10. BEHAVIORAL HEALTH
a) attention deficit disorder [ ] Yes [ ] No
b) psychological disorder [ ] Yes [ ] No
c) suicide attempt [ ] Yes [ ] No
d) eating disorder [ ] Yes [ ] No

11. OTHER
a) organ or other type of transplant or implant [ ] Yes [ ] No
b) breast disorder [ ] Yes [ ] No
c) lupus [ ] Yes [ ] No

G. Within the last 5 years, has anyone named in this application to be covered by this insurance had any other injury, illness or treatment for any condition not already listed; been hospitalized or been scheduled for hospitalization; had surgery or had surgery scheduled; had a test or a test scheduled; or been recommended to have a test or surgery which was not performed for any reason not already mentioned in this application? *We are not seeking the results of HIV Antibody test*. [ ] Yes [ ] No

H. In the space below please list and provide the complete details if you answered "Yes" above to any of the questions or conditions contained in sections *A through G*. (Attach additional pages as needed and sign the additional pages.)

Question Number	Name of Person	Date(s) of Treatment	Give full details for each question answered "Yes," state the condition, duration and degree of recovery.	Name and address of attending physician or other health care provider.

I. If anyone named in this application is taking medication or has had prescribed or recommended any medication during the period of time related to your answer (i.e. past 5 years, past 10 years, or currently taking), please list all those medications, dosages, and what medical condition is being treated or were treated by each medication in the space provided below. (Attach additional pages as needed and sign the additional pages.)

Name of Person	Name, dosage and frequency of medication (*include illness or health condition for which medication was prescribed*)	Date(s) medication taken (*indicate if ongoing)*	Name and address of prescribing physician or licensed health care provider and dispensing pharmacy

V. WAIVER OF COVERAGE

I understand that I am eligible to apply for group health insurance through my employer. I do NOT want, and hereby waive, group health insurance for (check the box that applies):

☐ Waiving for myself ☐ Waiving for my spouse ☐ Waiving for my dependent child(ren)
☐ Waiving for me, my spouse and my dependent child(ren)

I am waiving group health insurance because (check all that apply):

☐ I, the employee, am covered or will be covered under another plan that is not sponsored by my employer. I am not enrolled for coverage under the Health Insurance Risk-Sharing Plan (HIRSP). If currently covered, please attach a copy of your identification card for that plan.

[ ] I, the employee, do not have a risk characteristic or other attribute that would be the sole cause for the small employer insurer to make a decision with respect to premiums or eligibility for a policy that is adverse to the small employer.

- ☐ My spouse is covered or will be covered under another plan that is not sponsored by this employer. My spouse is **not** enrolled for coverage under the Health Insurance Risk-Sharing Plan (HIRSP). If currently covered, please attach a copy of your spouse's identification card for that plan.
- ☐ My dependent child(ren) is covered or will be covered under another plan that is not sponsored by my employer. My dependent child(ren) is **not** enrolled for coverage under the Health Insurance Risk Sharing Plan (HIRSP). If currently covered, please attach your identification card for that plan. Please list, below, the name(s) of the child(ren) for whom coverage is being waived.
- ☐ I am **not** enrolled under the Health Insurance Risk-Sharing Plan (HIRSP) and the annualized premium contribution to be paid by me on behalf of myself or my dependent spouse and child(ren) would exceed 10% of my **annualized gross earnings from this employer**.
- ☐ Other reason (Please provide a written reason for waiving coverage):

_____

WAIVER: I certify that I have been given the opportunity to apply for group health insurance and decline to enroll as indicated above, on behalf of myself, my spouse and my dependent child(ren). I understand that by signing this waiver, I, my spouse, and my dependent child(ren) forfeit the right to coverage. I was not pressured, forced or unfairly induced by my employer, the agent or the insurer(s) into waiving or declining the group health insurance. If in the future I apply for coverage, I, my spouse, or any of my dependent child(ren) may be treated as a late enrollee and subject to postponement or an exclusion of coverage for preexisting conditions for a period of up to 18 months. This period may be offset by the time I, my spouse or my dependent child(ren) was covered under a qualified health plan.

I understand that if I am declining enrollment for myself, my spouse, or my dependent child(ren) because of other health insurance coverage, including Medicaid, I may in the future be able to enroll myself, my spouse, or my dependent child(ren) in this plan, provided that I request enrollment within 30 days after my other health coverage ends or 60 days after Medicaid ends. In addition, if I gain a dependent spouse or child(ren) as a result of marriage, birth, adoption, or placement for adoption, I understand that I may be able to enroll myself, my spouse and my dependent child(ren), provided that I request enrollment within 30 days after the marriage, birth, adoption or placement for adoption. If I am declining enrollment for myself, my spouse or my dependent child(ren) because of coverage under Medicaid, I understand that if I, my spouse or my dependent child(ren) become eligible for group health plan premium assistance under Medicaid, I may be able to enroll myself, my spouse or my dependent child(ren), provided I request enrollment within 60 days of initial eligibility for the premium assistance. I understand that I can obtain enrollment information from my employer or small employer group health insurance carrier.

Signature of Employee: _____ Date Signed: _____

VI. MEDICARE INFORMATION

If you need to complete this section for more than one person, **please use a separate sheet of paper and attach it to this application (please sign and date the additional sheet)**.

Are you, your spouse or your child(ren) covered by Medicare Part A? [ ] Yes [ ] No Medicare Part B? [ ] Yes [ ] No Medicare Part D [ ] Yes [ ] No
Name of person covered by Medicare: _____

If "Yes," reason for Medicare: [ ] Over Age 65 [ ] Disability [ ] End-Stage Renal Disease (ESRD) [ ] Disability and ESRD

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

VII. CURRENT AND PREVIOUS COVERAGE

The information you provide about your other individual or group health insurance coverage (either prior or current) is necessary to determine whether you will have any waiting periods for preexisting conditions under the group health insurance plan under which you are applying for coverage. Your information will also help the small employer insurer(s) to coordinate benefits with any other group health coverage you may have. By providing this information you are not reducing your group health insurance for which you are applying.

Do you, your spouse or your dependent child(ren) listed in this application have current health insurance coverage or had previous health insurance coverage within the last 18 months? [ ] Yes [ ] No

If "Yes," please complete the following table and attach a copy of the Certificates of Creditable Coverage for each person.

Starting with you, the employee, identify each person applying for insurance and include information for all current and previous health insurance coverage(s) in effect during the last 18 months.