Unity Health Insurance
Affiliated with UW Health

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Sauk City, WI 53583-1374
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EMPLOYEE APPLICATION

Please Complete Entire Form in BLACK INK.

EMPLOYMENT INFORMATION:

Name of Employer Group: | Hours Worked Per Week:

Employment Status: ☐ Active ☐ Retired ☐ LOA | Requested Effective Date of Coverage: _____/_____/_____ | Date Employed: _____/_____/_____

Plan Requested: ☐ HMO ____________ ☐ POS ____________ ☐ PPO ____________

Type of Coverage: ☐ Employee ☐ Employee and Spouse ☐ Employee and Child(ren) ☐ Family

Reason for Enrollment: ☐ New Hire ☐ Marriage Date _____/_____/_____ ☐ Loss of Other Insurance ☐ Add a Dependent ☐ Name Change ☐ Open Enrollment

EMPLOYEE INFORMATION (Please do not use abbreviations or nicknames on this application)

Applicant's Last Name | First Name | MI | Social Security Number or Tax ID Number ___ ___ ___ – ___ ___ – ___ ___ ___ ___

Mailing Address | City | State | Zip Code | County

Date of Birth _____/_____/______ | Gender ☐ M ☐ F | Marital Status ☐ Single ☐ Divorced ☐ Married__________ *(provide date when marriage occurred)* | Primary Language Spoken ☐ English ☐ Spanish ☐ Other__________

Home Phone # (   ) | Work Phone # (   )

Cell Phone # (   ) | Applicant's E-Mail Address:

*Primary Care Physician (PCP) and Clinic: | Current Patient? ☐ Yes ☐ No

**If you want Unity to assign you to a Clinic or a PCP, indicate "ASSIGN"*

APPLICANT INFORMATION – Please list all other Members to be covered:

Dependent Name (Last, First, MI) | Social Security Number or Tax ID Number ___ ___ ___ – ___ ___ – ___ ___ ___ ___

Mailing address if different than subscriber:

Relationship | Date of Birth _____/_____/______ | Gender ☐ M ☐ F | *Clinic and PCP Name | Current patient? ☐ Yes ☐ No

Dependent Name (Last, First, MI) | Social Security Number or Tax ID Number ___ ___ ___ – ___ ___ – ___ ___ ___ ___

Mailing address if different than subscriber:

Relationship | Date of Birth _____/_____/______ | Gender ☐ M ☐ F | *Clinic and PCP Name | Current patient? ☐ Yes ☐ No

Dependent Name (Last, First, MI) | Social Security Number or Tax ID Number ___ ___ ___ – ___ ___ – ___ ___ ___ ___

Mailing address if different than subscriber:

Relationship | Date of Birth _____/_____/______ | Gender ☐ M ☐ F | *Clinic and PCP Name | Current patient? ☐ Yes ☐ No

Dependent Name (Last, First, MI) | Social Security Number or Tax ID Number ___ ___ ___ – ___ ___ – ___ ___ ___ ___

Mailing address if different than subscriber:

Relationship | Date of Birth _____/_____/______ | Gender ☐ M ☐ F | *Clinic and PCP Name | Current patient? ☐ Yes ☐ No

OTHER INSURANCE INFORMATION:

Will you or any of your dependents continue to have other insurance, including Medicare, after the Unity Health Insurance effective date of this policy? If Yes, complete –

Name(s) of Insured	Employer	
Insurance Company	Subscriber #	Group #
Effective Date of Coverage	Insurance Company Phone #	

Do you or any dependents have medical coverage that has ended or will end within 30 days? If Yes, complete –

Insurance Company	Phone #	Subscriber #
Effective Date of Coverage	Termination Date	
Names of those covered under policy		

Are you or any dependents listed above involved in a Workers Compensation case? ☐ Yes ☐ No

If Yes, indicate who is involved and start date / accident date:

Workers Compensation Condition:

Insurance Company Name

Insurance Company Address (where claim is sent)

Insurance Company Phone Group #	Effective Date: Term Date (if applicable):

WAIVER of GROUP COVERAGE:

I elect not to apply for the Group Health Benefit Plan coverage: ☐ Employee ☐ Spouse ☐ Children

Reason for waiving coverage: *(please see back of form for additional information)*

☐ I / we will be covered by a health benefit plan which provides similar benefits. Name of Insurance Company: _____

☐ I / we will be enrolled in a similar health benefit plan offered by my employer. Name of Insurance Company: _____

☐ The annualized premium contribution to be paid by me for Unity would exceed 10% of my annualized gross earnings.

☐ Other _____

I understand that group enrollment and / or eligibility for benefits may be conditioned upon my willingness to provide Unity with additional health information from me, my spouse or any dependents applying for coverage under this application. To the best of my knowledge, all statements and answers in this application are complete and true. I understand that any fraudulent statement or intentional misrepresentation of material fact may result in denial of a claim and / or rescission of coverage.

Date: _____ Employee Signature: _____

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.