

HEALTH ENROLLMENT FORM

CITY OF MILWAUKEE

Section A	SELECT A HEALTH PLAN UnitedHealthcare CHOICE <input type="checkbox"/> UnitedHealthcare CHOICE PLUS <input type="checkbox"/>		6 DIGIT EMPLOYEE ID	DESIRED COVERAGE Single <input type="checkbox"/> Family <input type="checkbox"/>	SOCIAL SECURITY NUMBER or MEDICARE ID#			
SUBSCRIBER LAST NAME		FIRST NAME	M. I.	HOME ADDRESS	CITY	STATE	ZIP	
JOB TITLE	CITY START DATE	RETURN TO WORK DATE	MARITAL STATUS SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/>		GENDER MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>	BIRTH DATE / /	HOME TELEPHONE NUMBER	EMAIL ADDRESS

Section B – Dependent Enrollment Information Complete For All Eligible Family Members For Whom You Are Requesting Coverage. Domestic Partners require pre-registration prior to enrollment.

LAST NAME	FIRST NAME	M.I.	GENDER	BIRTH DATE mm/dd/yy	SOCIAL SECURITY NUMBER	RELATIONSHIP: Spouse / Domestic Partner / Dependent / Adult Child / Other (please indicate relationship)
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Section C – Indicate Purpose For Submitting This Enrollment Application By Checking The Applicable Box Below. (In the event of marriage or divorce, please provide name change information.)

INITIAL ENROLLMENT
 DIVORCE (Provide Date) ___/___/___
 DELETE DEPENDENT / ADULT CHILD (Name) _____
 DEATH (Provide Date) ___/___/___

OPEN ENROLLMENT
 ADD DEPENDENT / ADULT CHILD
 MARRIAGE (Provide Date) ___/___/___ (Maiden Name) _____

RETURN TO WORK
 FAMILY STATUS CHANGE
 NAME CHANGE (From/To) _____/_____

Section D - EVERY SUBSCRIBER MUST COMPLETE THE FOLLOWING INFORMATION. Write in the information requested and/or check the appropriate box.

- Is your spouse employed? YES NO If "YES," indicate employer name/address: _____ Telephone Number: _____
- Is anyone named on this application covered under another group health policy? YES NO
If "YES", what is the name of the insurance company? _____ Policy Number: _____
- Are you and/or any dependent covered by **MEDICARE**? YES NO If "YES," provide a copy of each person's **MEDICARE ID Card**.
- Is anyone named in this application disabled, mentally incompetent, or unable to perform normal work /age-related activities? YES NO If "YES," please indicate name here. _____

Section E - SIGNATURE BLOCK (This application is not valid without being signed and dated.)

I apply for enrollment under the terms and conditions of my employer's Health Plan as administered by the entity stated in BOX 1 and subject to the authorization on the reverse side. I understand that coverage is not in force until the effective date shown on the ID card issued to me. I authorize any payroll/pension deductions that may be necessary to cover the cost of my plan. To the best of my knowledge, all statements and answers in this application are complete and true.

SUBSCRIBER SIGNATURE: _____ DATE: _____

Active Employees: Return completed form to Employee Benefits. **Retirees:** Return completed form to Employee's Retirement System

NOTICE TO EMPLOYEES AND RETIREES REGARDING THE THIRTY DAY RULE:

Employees and Retirees are responsible for keeping their enrollment status current – notifying the Employee Benefits Division or the Employees' Retirement System within 30 days of births, adoptions, marriages (including marriage to another City employee), divorces, dependents ceasing to be dependents, former dependents who become eligible dependents again, deaths and Medicare coverage, or active employees may logon to <https://cmil.mycmsc.com>. New employees must complete health and dental application within 30 days of their City start date and employees returning to work must also complete health and dental applications within 30 days of their return-to-work date. (Non-compliance with this Thirty-Day Rule may expose the City and/or you to additional costs.) There will be no exceptions to this rule.

AUTHORIZATION FOR DISCLOSURE OF INFORMATION

By my signature on the reverse side, I hereby authorize:

- (1) Any physician, medical practitioner, hospital, clinic, medically related facility or other institution who provided treatment or service to me, my spouse or my minor child(ren) at any time, or their agent(s) (including billing serve) which are subject to the provisions of Sections 146.81-83 of the Wisconsin Statutes, having medical information which includes but is not limited to, identification, medical history, diagnosis, prognosis, consultations, advice, treatments, services, dates of treatments, and/or services, test results (excluding the results of a test for the present of an antibody to HIV (AIDS virus antibody test), but including x-rays, summary reports, without limitation to period of treatment, diagnostic or therapeutic information, history or type of injury or illness including pregnancy and treatment of service, if any, for mental or nervous condition, alcohol abuse or drug abuse including: (a) all programs in which the patient has been enrolled as an alcohol or drug abuse patient; and (b) reports of treatment or service rendered for mental illness, developmental disabilities, alcoholism and drug dependence which are subject to provisions of Section 51.30 of the Wisconsin Statute, and
- (2) Any insurance or reinsuring company, service or prepaid benefit plan, plan administrator, consumer reporting agency, employer or personal or business associate having non-medical information about me, my spouse or my minor child(ren).

To disclose to the Health Plan (the Plan) on the reverse side or its representative(s) all such information (including photographic copies thereof), as may be requested from time to time.

I understand that said information will be used by the Plan for payment of claims, third party indemnification, auditing and cost containment measures under the Administrative Services Agreement between the plan and the City of Milwaukee. I agree that the Plan may release said information to its representative(s) or other person(s) or organization(s) performing business or legal services in connection with my claims(s) or the claim(s) of my spouse or minor child(ren) or as may be otherwise permitted by law or as I may further authorize from time to time.

I further hereby authorize the Plan to furnish and deliver to the City of Milwaukee or its representative(s), in accordance with said Agreement, said information and also the cost of treatments and/or service, dates of said payment(s), recipients of said payment(s) and such other claims information as provided under said Agreement. I understand that such disclosure to the City of Milwaukee is for purposes of payment of claims, third party indemnification, auditing and cost containment measure under said Agreement.

I understand that I may request and receive a copy of this authorization. I understand that this authorization is revocable upon advance written notice given to the plan at its office, except that any information released in reliance thereon and prior to such revocation cannot be retrieved and the Plan and its directors, officers, employees, and agents shall not be held responsible or liable for such release. I understand that this authorization will remain valid for three years from the date my legal representative or I execute this authorization.

I further understand that a photographic copy of this authorization is as valid as the original.

TERMS AND CONDITIONS

I understand and represent:

1. I have read this document or it has been read to me.
2. The answers provided within this entire application for coverage are to the best of my knowledge and belief, true and complete.
3. Neither my employer nor the agent has the authority to waive a complete answer to any question, determine coverage or insurability, alter any contract, or waive any other rights and requirements.
4. If this application for coverage is accepted, coverage will be effective on the date specified by the Plan on the certificate of coverage/certificate of insurance.
5. Any misrepresentation contained herein relied on by the Plan may be used to reduce or deny a claim or void the contract within the contestable period if such misrepresentation materially affected the acceptance of the risk.

I hereby enroll for benefits for which I am presently eligible or for which I may become eligible under my employer's group contract(s). If any deductions are required for this coverage, I authorize such deductions from my earnings. I reserve the right to revoke this deduction authorization at any time upon written notice unless I have chosen to use pretax deductions.

This document, together with any supplements, will form part of any contract and be the basis for any certificate of coverage/certificate of insurance issued.

My dependents and I authorize the Plan, any physician, medical or health care practitioner, hospital, clinic, veterans administration facility, other medical or medically-related facility, third party administrator, Pharmacy Benefit Manager, insurance, or reinsuring company, the Medical Information Bureau, Inc., employer, the Consumer Reporting Agency or banking and financial institutions having information regarding myself and my dependents, including information concerning, advice, diagnosis, treatment and care of the physical, psychiatric, mental or emotional conditions, drug, substance or alcohol abuse, illness, and any information that is not personal medical information to include motor vehicle reports and credit reports to give any and all such information to the Plan, its reinsurer or its legal representatives, and its affiliates.

1. The information obtained by use of this authorization may be used by the Plan to determine eligibility for coverage, eligibility for benefits under an existing policy, plan administration, and make claim determinations.
2. Any information obtained will not be released by the Plan to any person or organization except to reinsuring companies, the Medical Information Bureau, Inc., or other persons or organizations performing health care operations or business or legal services in connection with an application, claim or as may be otherwise lawfully required, or as the Plan may further authorize.
3. Once personal and health (including medical, dental and pharmacy) information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal and state privacy requirements.
4. A copy of this authorization is available to me or my legal representative upon written request.
5. This authorization shall be valid for two years from the signature date on the front side.
6. I have the right to revoke this authorization at any time:
 - a. To revoke this authorization, I must do so in writing and send my written revocation to the Plan's Privacy Office.
 - b. The revocation will not apply to information that has already been released in response to this authorization.
 - c. The revocation will become effective after it is received by the Plan's Privacy Office.