ORDER OF THE OFFICE OF THE COMMISSIONER OF INSURANCE AMENDING A RULE

To amend Ins 8.49 Appendix 1, Wis. Adm. Code, relating to small employer uniform employee application for group health insurance.

ANALYSIS PREPARED BY THE OFFICE OF THE COMMISSIONER OF INSURANCE (OCI)

1. Statutes interpreted:

ss. 600.01, 628.34 (12), 635.10, Stats.

2. Statutory authority:

ss. 601.41(3), 601.41 (8), 635.10, 635.18 (8), Stats.

3. Explanation of the OCI's authority to promulgate the proposed rule under these statutes:

In accordance with s. 601.41 (8), Stats., the office of the commissioner of insurance is required to revise the uniform small employer application form at least once every two years in consultation with the life and disability advisory council. The rule was initially promulgated in 2003, and due to federal changes and a request of the life and disability advisory council the office of the commissioner of insurance proposes this rule.

4. Related Statutes or rules:

Section 635.10, Stats., requires use of the small employer uniform employee application for group health insurance.

5. The plain language analysis and summary of the proposed rule:

The federal Medicare program has implemented a new drug benefit program known as Medicare Part D that first becomes effective January 1, 2006, for eligible individuals. Additionally the federal government has also modified the Health Insurance Portability and Accountability Act (HIPAA) to include the requirement of additional descriptive information for persons who after a qualifying event are permitted the option of a special enrollment period to understand how to obtain and apply for coverage. The proposed rule incorporates reference to Medicare Part D and amends the notification portion of the uniform application to include the additional information required by HIPAA.

Specifically, the modifications include 3 edits to the small employer uniform application for group health insurance. In section V of the application a sentence has been added in accordance with an amendment to HIPAA that informs an employee how to obtain information on electing health insurance coverage through a special election period due to a qualifying event. This information is to be provided at the time the employee waives the right to obtain health insurance through the small employer. At the request of the life and disability advisory council the signature line for spouses in section V was deleted. In addition, technical grammatical corrections were made to the application as identified by legislative council. The final two edits occur in section VI of the application to include the option for the applicant to indicate that the employee, dependent or spouse has Medicare Part D and the date the coverage began. These changes comply with the Medicare Prescription Drugs, Improvement and Modernization Act (MMA) of 2003.

During the July 2005 meeting of the life and disability advisory council, a motion was passed to request the office of the commissioner of insurance to modify the uniform application to comply with the MMA and HIPAA changes. The proposed rule incorporates the changes requested by the council in accordance with MMA and HIPAA. Failure to amend the current rule will result in insurers being unable to properly underwrite the small employer group since it would lack Medicare Part D participation information and an employee may not have sufficient information needed to make an appropriate election decision following a qualifying event.

In order to meet the deadlines required by the MMA and HIPAA the office of the commissioner of insurance is promulgating this rule both as an emergency rule and as a permanent rule concurrently. The hearing that is scheduled for November 8, 2005 will meet both hearing requirements within ss. 227.17 and 227.24 (4), Stats.

Section 8.49 may be enforced under ss. 601.41, 601.64, 601.65, Stats., or ch. 645, Stats., or any other enforcement provision of chs. 600 to 646, Stats.

6. Summary of and preliminary comparison with any existing or proposed federal regulation that is intended to address the activities to be regulated by the proposed rule:

There is no existing or proposed federal regulation related to a uniform employee application for small employer group health insurance.

7. Comparison of similar rules in adjacent states as found by OCI:

Iowa: None as to the small employer uniform application for group health insurance.

Illinois: None as to the small employer uniform application for group health insurance.

Minnesota: None as to the small employer uniform application for group health insurance.

Michigan: None as to the small employer uniform application for group health insurance.

8. A summary of the factual data and analytical methodologies that OCI used in support of the proposed rule and how any related findings support the regulatory approach chosen for the proposed rule:

The office of the commissioner of insurance reviewed the HIPAA and MMA regulations to ensure that the proposed modifications are necessary and will enable the application to be compliant with federal requirements effective January 1, 2006.

9. Any analysis and supporting documentation that OCI used in support of OCI's determination of the rule's effect on small businesses under s. 227.114:

There are no insurers that offer small employer group health insurance that qualify as small businesses in accordance with s. 227.114 (1), Wis. Stat. Intermediaries that solicit small employer group health insurance will be required to use the new form but since it is available at no cost from the office, the effect will be minimal.

10. If these changes may have a significant fiscal effect on the private sector, the anticipated costs to be incurred by private sector in complying with the rule:

There will be no significant fiscal effect on the private sector as the modifications are very minor and will assist in ensuring employees have information with which to make informed decisions and assist in coordinating benefits with the federal Medicare program.

11. Effect on Small Business:

This rule will necessitate the use of the revised form by small businesses, however the effect is not significant.

SECTION 1. Section Ins 8.49, Appendix 1 parts III, IV, V, VI and X, and the Authorization to use and disclose protected health information are amended to read:

APPENDIX 1 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	Full-Time Student (if 18 years old or older)
			Spouse			
			[ ] Child [ ] Stepchild [ ] Grandchild [ ] Other _____			School _____ Graduation Date _____ Credits/Semester _____
			[ ] Child [ ] Stepchild [ ] Grandchild [ ] Other _____			School _____ Graduation Date _____ Credits/Semester _____

b) If required by the insurer, for a dependent child(ren) who is 18 years of age or older and who ~~are~~is a full-time ~~students~~student, do you provide at least 50% of the dependent's support? [ ] Yes [ ] No
If "No," provide the name(s) of the dependent child(ren) for whom you do **not** provide 50% support.
_____
_____

c) Does the dependent child(ren) named within this application live with you at the address ~~show~~shown above? [ ] Yes [ ] No
If "No," please list the dependent child(ren)'s name and address(es):
_____
_____

d) Is anyone named in this application now disabled, mentally incompetent or unable to perform normal work or age-related activities? [ ]Yes [ ] No
If "Yes," please identify name(s), health condition(s), date(s) of disability and name(s) and address(es) of the attending physician(s):
_____
_____

e) If there is a stipulation in a legal decree or court order stating who is responsible for providing health insurance of the named dependent child(ren), please indicate name of the person who has primary custody of the dependent child(ren) and the name of the responsible person for health insurance:
_____
_____

IV. MEDICAL INFORMATION

Please answer the following questions to the best of your knowledge. On the next page, please provide the complete details if you answer "Yes" to any of the questions below. The date that this application is signed is the date from which you should use when answering questions that request you to provide prior history for various periods of time. **You are required to promptly notify your employer so that you may provide updated information to the small employer insurer(s) of any changes or developments in your, your ~~spouse~~spouse's or your dependent child(ren)'s health history that occur prior to your employer's notifying you that there has been an insurer's underwriting decision regarding this application.**

A. Are you, your spouse or any dependent child(ren) (even if not listed on the application) currently pregnant or an expectant parent? (If "Yes," due date is _____) [ ] Yes [ ] No
B. Has anyone named in this application been treated or diagnosed by a medical professional as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? [ ] Yes [ ] No
C. Has anyone named in this application used tobacco or smokeless tobacco during the past 12 months? [ ] Yes [ ] No
If "Yes," provide information as requested regarding the product, duration and frequency of use in section H below.
D. In the past 5 years has anyone named in this application been evaluated or treated for alcoholism or chemical dependency; or joined any organization for alcoholism or chemical dependency; or used illegal drugs or been advised by a health care professional to reduce the use of alcohol or illegal drugs? [ ] Yes [ ] No
E. Within the past 10 years, has anyone named in this application been counseled, consulted or treated for any of the following (please check all conditions that apply):

1. CIRCULATORY SYSTEM
a) heart disease or disorder [ ] Yes [ ] No
b) stroke [ ] Yes [ ] No
c) circulatory disorder [ ] Yes [ ] No
d) chest pain [ ] Yes [ ] No
e) high or low blood pressure [ ] Yes [ ] No
f) elevated cholesterol and/or triglyceride levels [ ] Yes [ ] No
g) anemia or blood disorder [ ] Yes [ ] No

2. DIGESTIVE SYSTEM
a) ulcers [ ] Yes [ ] No
b) stomach disorder [ ] Yes [ ] No
c) liver/pancreas disorder [ ] Yes [ ] No
d) gallbladder disorder [ ] Yes [ ] No
e) intestinal disorder (e.g., colitis, Crohn's disease) [ ] Yes [ ] No
f) hernia [ ] Yes [ ] No
g) rectal disorder [ ] Yes [ ] No

3. GENITOURINARY SYSTEM
a) menstrual disorder [ ] Yes [ ] No
b) genital disorder [ ] Yes [ ] No
c) sexual dysfunction [ ] Yes [ ] No

3. GENITOURINARY SYSTEM (continued)
d) pregnancy complications (e.g., premature birth, miscarriage, c-section) [ ] Yes [ ] No
e) infertility [ ] Yes [ ] No
f) urinary tract/kidney/bladder disorder [ ] Yes [ ] No
g) prostate disorder [ ] Yes [ ] No

4. ENDOCRINE SYSTEM
a) diabetes [ ] Yes [ ] No
b) thyroid disorder [ ] Yes [ ] No
c) adrenal disorder [ ] Yes [ ] No
d) enlargement of the lymph-nodes [ ] Yes [ ] No
e) connective tissue disorder [ ] Yes [ ] No

5. RESPIRATORY SYSTEM
a) allergy(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

6. 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

7. NERVOUS SYSTEM

a) epilepsy or other seizures [ ] Yes [ ] No
b) headaches [ ] Yes [ ] No
c) multiple sclerosis [ ] Yes [ ] No

8. CANCER

a) cancer [ ] Yes [ ] No
b) tumor [ ] Yes [ ] No

8. CANCER (continued)

c) abnormal growth [ ] Yes [ ] No
d) carcinoma in situ [ ] Yes [ ] No

9. EAR OR EYE

a) eye disorder [ ] Yes [ ] No
b) ear disorder [ ] 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

F. 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

G. 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 F*. **(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.

H. 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 wil 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, 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. 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. I understand that I can obtain enrollment information from my employer or small employer group health insurance carrier.

Signature of Employee: _____ Date Signed: _____

~~Signature of Spouse:~~ _____ ~~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 ~~+ Choice~~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.

Name	Insurance Company, Plan & Group Number	Effective Date of Coverage (mo/day/yr)	Termination Date of Coverage (mo/day/yr)	Reason for Termination of Coverage	Type of Coverage (see key below)

Type of Coverage Key: **G** = Group Comprehensive Major Medical; **I** = Individual Comprehensive Major Medical;
M = Medicare Supplement; **D** = Drug Coverage Only; **H** = Hospital Coverage Only; **V** = Vision Coverage Only

VIII. HEALTH PROVIDER OR PRODUCT SELECTION, IF APPLICABLE

This section should be completed only if the small employer group insurance for which you are applying requires the selection of a network, primary care provider or clinic. If applicable, it should also be used to select the product options offered by the employer or insurer. With respect to the provider or network selection, a selection should be made for each individual applying for such coverage and for each insurer from which insurance coverage is being sought. The provider numbers may be listed in the provider materials (i.e., directory) that are supplied by each insurer to your employer. The provider numbers for the same provider may not be the same for different insurers or products. **Use additional sheets if necessary.**

Insurer: _____
Product Type: _____
Coinsurance Option: _____ Deductible Option: _____ Copayment Option: _____
Selected Provider is for (choose only one): [ ] Health Insurance [ ] Dental Insurance [ ] Other _____

Covered Person's Name	Network or Provider's Name or Number	Is this your current provider?

Insurer: _____
Product Type: _____
Coinsurance Option: _____ Deductible Option: _____ Copayment Option: _____
Selected Provider is for (choose only one): [ ] Health Insurance [ ] Dental Insurance [ ] Other _____

Covered Person's Name	Network or Provider's Name or Number	Is this your current provider?

IX. NON-HEALTH INSURANCE COVERAGE SELECTION, IF APPLICABLE

Availability of coverage is determined by your employer and whether the coverage is approved for issuance by the insurer(s).
Please list the insurer(s) below from whom you are applying for coverage and check all benefits for which you are applying.
If you have been given a choice of plans to apply for, or if the coverage you are applying for requires the selection of a primary care provider/clinic/network, please complete the section entitled "Provider and/or Product Selection."
If you are waiving application for any coverage on yourself and/or your spouse and/or dependent child(ren), please complete the **"Waiver of Coverage"** section at the end of this section.

A. GROUP DENTAL COVERAGE

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

Insurer: _____ **Insurer:** _____

Insurer: _____ **Insurer:** _____

Within the past 12 months, have you, your spouse or your dependent child(ren) had any individual or other group dental coverage? [ ] Yes [ ] No
If "Yes," please provide the following information:
Orthodontia coverage? [ ] Yes [ ] No
Dental Insurer Name: _____ Policy Number: _____
Address: _____ Phone Number: _____
Coverage Effective Date: _____ Termination Date: _____
Is coverage still in effect? [ ] Yes [ ] No
Who was or is covered under the policy listed above? _____
Please attach copies of Certificates of Prior Coverage.

B. GROUP LIFE/AD&D COVERAGE (dependent coverage only available if employee coverage elected)

Insurer: _____ **Insurer:** _____

Insurer: _____ **Insurer:** _____

Employee Life/AD&D Amounts: **Basic Issue $**_____ **Supplemental $**_____ **Optional $**_____

Primary Beneficiary Name _____ Beneficiary's Social Security _____
Relationship of Beneficiary _____

Secondary Beneficiary Name _____ Beneficiary's Social Security _____
Relationship of Beneficiary _____

Dependent Life Amounts: **Basic Issue $**_____ **Supplemental $**_____ **Optional $**_____

[ ] Dependent Spouse Only **[ ] Dependent Child(ren) Only** **[ ] Dependent Spouse and Dependent Child(ren)**

C. GROUP DISABILITY COVERAGE (only available to employees)

[ ] Short Term Disability **[ ] Long Term Disability** Your Annual Salary $_____

Insurer: _____ **Insurer:** _____

Insurer: _____ **Insurer:** _____

Basic Benefit Amount $_____**/ per week** **Optional Benefit Amount $**_____**/ per week**

D. GROUP DRUG COVERAGE

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

Insurer: _____ **Insurer:** _____

Insurer: _____ **Insurer:** _____

E. GROUP VISION COVERAGE

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

Insurer: _____ **Insurer:** _____

Insurer: _____ **Insurer:** _____

F. WAIVER OF NON-HEALTH COVERAGE - This section must be completed if you or your dependents do NOT want the coverage listed above that is available to you through your employer.

I understand that I am eligible to apply for coverage through my employer. I do NOT want coverage for (check all that apply):

Employee: [ ] Dental [ ] Basic Life/AD&D [ ] Supplemental Life/AD&D [ ] Optional Life
[ ] Basic Disability [ ] Optional Disability [ ] Drug [ ] Vision

Spouse: [ ] Dental [ ] Basic Life [ ] Supplemental Life [ ] Optional Life [ ] Drug [ ] Vision

Dependent Child(ren): [ ] Dental [ ] Basic Life [ ] Supplemental Life [ ] Optional Life [ ] Drug [ ] Vision

The reason I am waiving group coverage at this time is because of:

[ ] Spousal coverage [ ] Individual Coverage [ ] Medicare [ ] Medical Assistance
[ ] Other:_____

WAIVER: I certify that I was not pressured, forced or unfairly induced by my employer, the agent, or the insurer(s) into waiving (declining) the above-noted coverage. I understand that in the event that I should decide to apply for such coverage at a later date, the application will be subject to the applicable terms and conditions of the employer's policy(s), which may require additional limitations and waiting periods. I also understand that I, my spouse and my dependent child(ren) may be required to furnish, at my own expense, evidence of health status/health history representation satisfactory to the insurer(s). I understand that the insurer(s) reserves the right to deny coverage with any future application for coverage.

Signature of Employee: _____ **Date Signed:** _____

Signature of Spouse: _____ **Date Signed:** _____

X. TERMS AND CONDITIONS

I hereby enroll for coverage under the insurance coverage(s) for which I am presently eligible, or for which I may become eligible under my employer's group contract(s). I have indicated in this Wisconsin Uniform Employee Application for Small Employer Group Health Insurance, if required, the Provider or Product Selection. I understand and agree that the information obtained by using this Application will be used by the insurer(s) to determine eligibility for benefits under my employer's group insurance policies. I, on behalf of myself, my spouse and my dependent child(ren), if any, named herein, agree to cooperate in providing the insurer(s) with information needed to process this Application. This might include signing a form for the release by hospitals, doctors, and other health care providers of pertinent heath care records to the Medical Information Bureau, the insurer(s) or their legal representatives.

I acknowledge that I have read and completed the entire Application. If I received assistance in reading or completing this Application, I have identified in the space provided below the person(s) who provided me with such assistance. I declare and agree that the answers are, to the best of my knowledge and belief, complete and true and, together with any supplements or addendums thereto, shall be the basis for any certificate of coverage or certificate of insurance issued. I understand and agree that neither the employer nor the agent has the authority to waive a complete answer to any question, pass on insurability, alter any contract, or waive any of the insurer's other rights or requirements. I additionally agree that the insurer(s) is not liable for any statement, representation, or other information provided to me, my spouse or my dependent child(ren) that is not expressly contained in a written document provided ~~to~~by the insurer and signed by an authorized officer of the insurer. I agree that no insurance will be effective until the date specified by the company on the certificate of coverage or certificate of insurance after this application has been accepted. I understand that any misrepresentation contained herein and relied upon by the insurer may be used to reduce or deny a claim or void the contract within the contestable period if such misrepresentation materially affects the acceptance of risk. I also understand that if I decline any coverage, future changes in coverage are NOT automatic and may be subject to the insurer's approval.

I understand and acknowledge that any person who, with intent to defraud or knowledge that the person is facilitating a fraud against an insurer, submits an application or files a claim containing a false deceptive statement is committing a fraudulent act that is a crime. I further understand and acknowledge that in some states, any person who, for the purpose of misleading an insurer or other person, conceals significant information from an application or claim is committing a fraudulent act.

If any payroll 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 to the employer. An Application should not be submitted more than 45 days prior to the effective date. This document will become a part of the insurance contract when coverage is approved and issued.

I understand that I may request a copy of this Application and the Authorization to Use and Disclose Protected Health Information that are part of this Application. I agree that a photographic copy shall be as valid as the original. A legible facsimile signature shall have the same force and effectiveness as the original.

Signature of Employee: _____ **Date Signed:** _____

Signature of Spouse: _____ **Date Signed:** _____

Signature of each listed dependent who has attained the age of 18:

_____ **Date Signed:** _____ **Print Name** _____

_____ **Date Signed:** _____ **Print Name** _____

Complete this section if someone assisted you in the completion of this Application.
The following person assisted me in completing the Application: _____
Please explain your relationship with the Applicant: _____

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Instructions: Please read this authorization form carefully before signing. This form must be signed by each adult person seeking coverage, including all adult dependent children. Parents should sign for their minor children unless the minor has received treatment without parental consent, consistent with state law. Your application cannot be processed without a signature for each person seeking coverage. Signing this form is a condition of coverage: if you decide not to sign, you will not be enrolled in a health plan of the insurers listed below. You have the right to receive a copy of this form following your signature.

I. Protected Health Information

By signing this form, I authorize certain organizations and persons to use or disclose my, my spouse's and my dependent child (ren)'s protected health information. Protected health information includes, but is not limited to, hospital records, physician records, lab results, mental health records, and alcohol and/or drug abuse records. Protected health information may be written, oral, or electronic. This form does not permit the use or disclosure of psychotherapy notes or the disclosure of information concerning whether I, my spouse or my dependent child(ren) have obtained a test for the presence of HIV antigen or nonantigenic products of HIV or an antibody to HIV or what the results of this test were.

II. Purpose of this Authorization Form

By signing this form, I, my spouse and my dependent child(ren) authorize the use and disclosure of protected health information for the purposes of pre-enrollment underwriting or risk-rating of health insurance coverage for me, my spouse and my dependent child(ren), to determine eligibility for enrollment or benefits under a health plan or to allow the insurer to conduct utilization review and quality improvement activities ("Purpose").

III. Entities Authorized to Use and Disclose My Protected Health Information

Insurers: I hereby authorize the following insurers, their reinsurers, and their legal representatives ("Insurers") to receive, use, and disclose my, my ~~spouse~~spouse's and my dependent child(ren)'s protected health information for the Purpose listed above:

Insurer: _____ **Insurer:** _____

Insurer: _____ **Insurer:** _____

I authorize the Insurers to disclose my, my ~~spouse~~spouse's and my dependent child(ren)'s protected health information: between themselves, to reinsuring companies, and to the plan administrator (if other than the employer), plan sponsor (if other than the employer), insurance intermediaries, or other persons or organizations performing business or legal services in connection with the Purpose above.

I further authorize any licensed physician, medical practitioner, health care provider, hospital, clinic, or other medical or medically related facility, insurance or reinsuring company, Medical Information Bureau, Inc., consumer reporting agency, or other organization, institution, or person that has any record or knowledge of me, my spouse or my dependent(s), to give to Insurers any and all protected health information about me, my spouse, or my dependent(s) to be covered concerning diagnosis, treatment and prognosis for any physical or mental condition, history or character, general reputation, personal trait, and mode of living, including, but not limited to, all medical and health care records, but not including whether I, my spouse or my dependent(s) obtained a test for the presence of HIV antigen or nonantigenic products of HIV or what the results of this test were.

I, my spouse and my dependent child(ren) understand that protected health information described in this form may be used by, or disclosed to or by, organizations and persons who are not subject to federal or state privacy laws.

IV. Term of Authorization

I agree this Authorization shall be valid for two and one half (2 ½) years from the latest signature date below.

V. Right to Revoke

I understand I, my spouse or my dependent child(ren) may revoke this authorization at any time by giving advance written notice to Insurers. Revocation of this authorization form will not affect actions Insurers and others took in reliance on this form prior to the written notice of revocation.

I HAVE HAD FULL OPPORTUNITY TO READ AND CONSIDER THIS FORM. I UNDERSTAND THAT, BY SIGNING THIS FORM, I AUTHORIZE THE USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION DESCRIBED IN THIS FORM. I UNDERSTAND THAT I MAY ONLY REVOKE AUTHORIZATION FOR MYSELF OR MY MINOR CHILD(REN) UNLESS MY MINOR CHILD(REN) HAS RECEIVED TREATMENT WITHOUT MY CONSENT, CONSISTENT WITH STATE LAW. (CONTINUED ON THE NEXT PAGE.)

_____	_____	_____
Signature of Adult Applicant	**Date signed**	**Printed Name**
_____	_____	_____
Signature of Spouse (if applicable)	**Date signed**	**Printed Name**

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION (Continued)

I HAVE HAD FULL OPPORTUNITY TO READ AND CONSIDER THIS FORM. I UNDERSTAND THAT, BY SIGNING THIS FORM, I AUTHORIZE THE USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION DESCRIBED IN THIS FORM. I UNDERSTAND THAT I MAY ONLY REVOKE AUTHORIZATION FOR MYSELF OR MY MINOR CHILD(REN) UNLESS MY MINOR CHILD(REN) HAS RECEIVED TREATMENT WITHOUT MY CONSENT, CONSISTENT WITH STATE LAW.

_____	_____	_____
Signature of Adult Dependent (if applicable)	**Date signed**	**Printed Name**
_____	_____	_____
Signature of Parent or Legal Guardian for Minor Child(ren) (if applicable)	**Date signed**	**Name of Minor Child** (please print)

If signing for more than one child, please list the names of each child for whom you are signing:

_____	_____
Name of Minor Child (please print)	**Name of Minor Child** (please print)
_____	_____
Name of Minor Child (please print)	**Name of Minor Child** (please print)

For services received by a minor that under state law the minor may consent to treatment without parental or legal guardian consent:

_____	_____	_____
Signature of Parent or Legal Guardian for Minor Child (if minor received treatment with knowledge of parent)	**Date signed**	**Name of Minor Child** (please print)
_____	_____	_____
Signature of Minor Child (if minor may have received treatment that does not require parent or legal guardian authorization)	**Date signed**	**Name of Minor Child** (please print)
_____	_____	_____
Signature of Minor Child (if minor may have received treatment that does not require parent or legal guardian authorization)	**Date signed**	**Name of Minor Child** (please print)

SECTION 2. These changes will take effect on the first day of the month after publication, as provided in s. 227.22(2)(intro.), Stats.

Dated at Madison, Wisconsin, this _____ day of March, 2006.

_____

Jorge Gomez
Commissioner of Insurance

Office of the Commissioner of Insurance
Private Sector Fiscal Analysis

For rule Ins 849 Appendix 1, relating to small employer uniform employee group health insurance application

This rule change will have no significant effect on the private sector as the modifications are very minor and will assist in ensuring employees have information with which to make informed decisions and assist in coordinating benefits with the federal Medicare program.

Wisconsin Department of Administration
Division of Executive Budget and Finance
DOA-2047 (R10/2000)

FISCAL ESTIMATE WORKSHEET — 2005 Session

Detailed Estimate of Annual Fiscal Effect

☒ ORIGINAL ☐ UPDATED	LRB Number	Amendment No. if Applicable
☐ CORRECTED ☐ SUPPLEMENTAL	Bill Number	Administrative Rule Number **INS 8.49**

Subject

Small employer uniform employee application for group health insurance

One-time Costs or Revenue Impacts for State and/or Local Government (do not include in annualized fiscal effect):

None

Annualized Costs:	**Annualized Fiscal impact on State funds from:**	
A. State Costs by Category	**Increased Costs**	**Decreased Costs**
State Operations - Salaries and Fringes	**$ 0**	**$ -0**
(FTE Position Changes)	(**0** FTE)	(**-0** FTE)
State Operations - Other Costs	**0**	**-0**
Local Assistance	**0**	**-0**
Aids to Individuals or Organizations	**0**	**-0**
TOTAL State Costs by Category	**$ 0**	**$ -0**
B. State Costs by Source of Funds	**Increased Costs**	**Decreased Costs**
GPR	**$ 0**	**$ -0**
FED	**0**	**-0**
PRO/PRS	**0**	**-0**
SEG/SEG-S	**0**	**-0**
C. State Revenues Complete this only when proposal will increase or decrease state revenues (e.g., tax increase, decrease in license fee, etc.)	**Increased Rev.**	**Decreased Rev.**
GPR Taxes	**$ 0**	**$ -0**
GPR Earned	**0**	**-0**
FED	**0**	**-0**
PRO/PRS	**0**	**-0**
SEG/SEG-S	**0**	**-0**
TOTAL State Revenues	**$ 0 None**	**$ -0 None**

NET ANNUALIZED FISCAL IMPACT

	STATE	LOCAL
NET CHANGE IN COSTS	$ **None 0**	$ **None 0**
NET CHANGE IN REVENUES	$ **None 0**	$ **None 0**

Prepared by: Julie E. Walsh	**Telephone No.** (608) 264-8101	**Agency** Insurance
Authorized Signature:	**Telephone No.**	**Date** (mm/dd/ccyy)

Wisconsin Department of Administration
Division of Executive Budget and Finance
DOA-2048 (R10/2000)

FISCAL ESTIMATE — 2005 Session

☒ ORIGINAL ☐ UPDATED

☐ CORRECTED ☐ SUPPLEMENTAL

LRB Number	Amendment No. if Applicable
Bill Number	Administrative Rule Number **INS 8.49**

Subject
Small employer uniform employee application for group health insurance

Fiscal Effect

State: ☒ No State Fiscal Effect

Check columns below only if bill makes a direct appropriation or affects a sum sufficient appropriation.

☐ Increase Existing Appropriation ☐ Increase Existing Revenues
☐ Decrease Existing Appropriation ☐ Decrease Existing Revenues
☐ Create New Appropriation

☐ Increase Costs - May be possible to Absorb Within Agency's Budget ☐ Yes ☐ No

☐ Decrease Costs

Local: ☒ No local government costs

1. ☐ Increase Costs ☐ Permissive ☐ Mandatory
2. ☐ Decrease Costs ☐ Permissive ☐ Mandatory
3. ☐ Increase Revenues ☐ Permissive ☐ Mandatory
4. ☐ Decrease Revenues ☐ Permissive ☐ Mandatory
5. Types of Local Governmental Units Affected: ☐ Towns ☐ Villages ☐ Cities ☐ Counties ☐ Others _____ ☐ School Districts ☐ WTCS Districts

Fund Sources Affected ☐ GPR ☐ FED ☐ PRO ☐ PRS ☐ SEG ☐ SEG-S

Affected Chapter 20 Appropriations

Assumptions Used in Arriving at Fiscal Estimate

The proposed modifications are critical for federal compliance but do not result in added cost to insurer, employer or consumer.

Long-Range Fiscal Implications

None

Prepared by:	Telephone No.	Agency
Julie E. Walsh	(608) 264-8101	Insurance
Authorized Signature:	**Telephone No.**	**Date** (mm/dd/ccyy)