

# Please Use this Guide for Assistance Completing the Non-Group Enrollment/Change Form

Sections 1 and 2 must be fully completed for enrollment processing



## Non-Group Enrollment/Change Form

PO Box 2078  
Madison, WI 53701-2078

1. Applicant Information (Please type or print in ink)							
Applicant (First Name, MI, Last Name) John J. Newform				Social Security # 999-99-9999		<input checked="" type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced	
Street Address 123 Main Street		City, State Madison, WI	Zip Code 99999	County Dane	Home Phone (999)555-1234 Work Phone (999)555-5678	E-mail address john@ppplusic.com	
List name(s) if you or any dependents are currently disabled				If self employed, list company name			
Application for: <input type="checkbox"/> Copay <input checked="" type="checkbox"/> HealthShare 250 <input type="checkbox"/> Conversion <input type="checkbox"/> HSA-Qualified <input type="checkbox"/> HealthShare Complete <input type="checkbox"/> Meriter Choice Reward Plan							
Riders (check to add coverage for): <input type="checkbox"/> Maternity <input type="checkbox"/> Mental Health & Substance Abuse <input checked="" type="checkbox"/> Prescription Drugs \$10 Generic RX							
Change: <input type="checkbox"/> Add Dependent(s) listed below <input type="checkbox"/> Delete Dependents listed below <input type="checkbox"/> Cancel All Coverage <input type="checkbox"/> Other (please explain):							
2. Family Information and Primary Care Physician (PCP) Selection							
Full Name of Members to be Covered	Relationship	Gender (M/F)	Social Security #	Birth date	PCP: First Name/Last Name/Provider # (call 608-282-8900 or 800-545-5015 for help)	Enrollment Dept. Use Only	Are you a current patient of this PCP?
Applicant John Newform	Self	M	999-99-9999	1/2/59	Adam Doctor, 608-222-3544		Yes
Spouse	Spouse						
Dependent							
Dependent							
If dependents listed above reside at a different address, please list their name(s) and address(es):							
3. Premium							
For new applications, payment must be submitted with application. <input type="checkbox"/> Monthly (provide one month's premium) <input type="checkbox"/> Quarterly (provide three month's premium) Premium Paid:							
4. Other Health Insurance Information							
If you have ever been covered by a Physicians Plus policy, please indicate year(s):							
On the day your Physicians Plus coverage begins, will anyone listed on this application be covered by other insurance: <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Medicare (If you check any, complete below)							
Insurance Company ABC Dental		Address 10 Main Street, Anytown, WI 99999			Phone (999) 555-4876		
Name of Insured John Newform	Birthdate 1/2/59		Dependents Covered				
Employer of Insured BFC, Inc.	Policy Number 77757		Policy Coverage Dates (Effective to Term) 1/1/09 to 1/1/10				
List anyone named above who is eligible for Medicare		Reason <input type="checkbox"/> Over 65 <input type="checkbox"/> Kidney Failure <input type="checkbox"/> Disability		Specify Medicare Part A, B, C or D and Effective Date		Medicare Number	
5. Authorization Signature to Obtain or Release Medical Information							
On behalf of myself and my eligible dependents, I hereby agree to the terms and conditions of enrollment and to the Authorization to Obtain or Release Medical Information, which appears above and on the reverse side of this application.							
Applicant Signature: <i>John Newform</i>		Date 8/24/09		Spouse/Partner Signature (if applicable)		Date	
If possible, please begin coverage on (choose month) NOV 1st. (Your application must be approved by the 20th of the month to be effective the 1st of the following month.)							
Writing Agent Name (print)		Writing Agent Signature		Physicians Plus Agent #		Date	
6. For Health Plan Use Only							
Group #		Effective Date		Check #		Check Amount	

White & Yellow Copies: Physicians Plus Pink Copy: Applicant

P-2943-0908

This section must be completed if any other medical insurance is in effect.

Sign and date here

If PCP Selection and current patient information are not completed, all claims will be denied and ID cards will not be sent. If you need assistance in selecting a PCP, please contact Member Service at (800) 545-5015 or ppinfo@ppplusic.com.

Provider Name

Schell, Debra, MD  
P+ Provider ID 1021251

Provider Number

**Applicant Note:** If you add a dependent due to adoption or change in custody, a copy of the official court document is required. Please review the Authorization Acceptance/Agreement on the reverse side of this page.

## Non-Group Application Acceptance/Agreement

By signing this application, I understand and agree that a) All statements and answers I provide are complete and true to the best of my knowledge and belief; b) The insurance I hereby apply for will be effective only when Physicians Plus Insurance Corporation (Physicians Plus) approves this application. Evidence of such approval is issuance of the Medical Certificate; and c) I authorize the use of a Social Security Number for purpose of identification.

I understand that I or my legal representative, not Physicians Plus, represents me, my spouse and my legal dependents for any and all purposes of this policy. I understand that any insurance agent or broker cannot modify, waive or change in any way this application, any requirement imposed by Physicians Plus, bind coverage or guarantee approval of this application. I further understand and agree that Physicians Plus, its directors, officers, employees and agents shall not be liable for any injury, damage or expense (including attorneys' fees), I, and/or my spouse and/or any of my dependent(s) suffer as a result of any improper advice, action or omission on the part of any health care provider.

### **Authorization to Obtain and Release Medical Information**

By my (our) signature on this application, I (we) authorize: (1) any physician, medical practitioner, hospital, clinic, medically-related facility or other institution who provided treatment or service to me, my spouse and/or my legal dependent(s) listed on the front of this form (to the extent permitted by law) at any time, or their agent(s) (including billing service), having medical information that includes, but is not limited to, identification, medical history, diagnosis, prognosis, consultations, advice, treatments, services, dates of treatments and/or services, test results (excluding any HIV antibody test or genetic test results, but including x-rays) or summary reports, without limitation to period of treatment, diagnostic or therapeutic information, history or type of injury or illness (including pregnancy) and treatment or service, if any, for mental or nervous conditions (excluding psychotherapy notes as defined by law), alcohol or drug abuse, including all programs in which the patient has been enrolled as an alcohol or drug abuse patient; 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 and/or my minor child(ren); to disclose to Physicians Plus or their representative(s) (including claims and underwriting departments) all such information (including photographic copies thereof).

I understand that said information will be used by Physicians Plus to determine eligibility for coverage, evaluate and audit claims and determine availability of benefits under the Physicians Plus non-group health insurance policy, benefit plan or other contract, if issued by Physicians Plus. I agree that Physicians Plus may release said information to its representative(s) or other person(s) or organization(s) performing business or legal services in connection with my claim(s) or the claim(s) of my spouse and/or my dependent(s) or as may be otherwise permitted by law or as I may further authorize from time to time.

I understand that I will receive a copy of this authorization. I understand that I have the right to inspect or copy the personal health information to be used or disclosed by Physicians Plus. I understand that this authorization is revocable upon advance written notice given to Physicians Plus at its office in Madison, Wisconsin, except that any information released in reliance thereon and prior to such revocation cannot be retrieved and Physicians Plus and its directors, officers, employees and agents shall not be held responsible or liable for such release.

I understand that Physicians Plus may not condition treatment, payment, enrollment or eligibility for benefits on the provision of this authorization. I also understand that I may refuse to sign this authorization; however, in doing so, Physicians Plus may condition payment of claims and services as permitted by law. I understand that this authorization will remain valid for up to thirty months from the date I or my legal representative execute this authorization or, if longer and permitted by law, for so long as the policy is in force under Physicians Plus. I further understand that a photographic copy of this authorization is as valid as the original.

I understand that I may obtain a detailed description of Physicians Plus's Notice of Privacy Practices from the Physicians Plus Web Site or I may obtain a copy by contacting Physicians Plus Insurance Corporation directly.

Signature of this Agreement does not authorize the use or disclosure of information which is prohibited under Section 631.90 Wisconsin Statutes as it relates to provisions concerning HIV or the use or disclosure of information which is prohibited under Section 631.89 Wisconsin Statutes as it relates to genetic tests.

**1. Applicant Information (Please type or print in ink)**

Applicant (First Name, MI, Last Name)				Social Security #		<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced	
Street Address		City, State	Zip Code	County	Home Phone ( ) Work Phone ( )		E-mail address
List name(s) if you or any dependents are currently disabled					If self employed, list company name		
Application for: <input type="checkbox"/> Copay ____ <input type="checkbox"/> HealthShare ____ <input type="checkbox"/> Conversion <input type="checkbox"/> HSA-Qualified ____ <input type="checkbox"/> HealthShare Complete ____ <input type="checkbox"/> Meriter Choice Reward Plan ____							
Riders (check to add coverage for): <input type="checkbox"/> Maternity <input type="checkbox"/> Mental Health & Substance Abuse <input type="checkbox"/> Prescription Drugs ____							
Change: <input type="checkbox"/> Add Dependent(s) listed below <input type="checkbox"/> Delete Dependents listed below <input type="checkbox"/> Cancel All Coverage <input type="checkbox"/> Other (please explain):							

**2. Family Information and Primary Care Physician (PCP) Selection**

Full Name of Members to be Covered	Relationship	Gender (M/F)	Social Security #	Birth date	PCP: First Name/Last Name/Provider # (call 608-282-8900 or 800-545-5015 for help)	Enrollment Dept. Use Only	Are you a current patient of this PCP?
Applicant	Self						
Spouse	Spouse						
Dependent							
Dependent							
Dependent							

If dependents listed above reside at a different address, please list their name(s) and address(es):

**3. Premium**

 For new applications, payment must be submitted with application.  Monthly (provide one month's premium)  Quarterly (provide three month's premium) Premium Paid:

**4. Other Health Insurance Information**

If you have ever been covered by a Physicians Plus policy, please indicate year(s):

 On the day your Physicians Plus coverage begins, will anyone listed on this application be covered by other insurance:  Health  Dental  Medicare (If you check any, complete below)

Insurance Company	Address		Phone ( )
Name of Insured	Birthdate	Dependents Covered	
Employer of Insured	Policy Number	Policy Coverage Dates (Effective to Term)	
List anyone named above who is eligible for Medicare	<b>Reason</b> <input type="checkbox"/> Over 65 <input type="checkbox"/> Kidney Failure <input type="checkbox"/> Disability	Specify Medicare Part A, B, C or D and Effective Date	Medicare Number

**5. Authorization Signature to Obtain or Release Medical Information**

On behalf of myself and my eligible dependents, I hereby agree to the terms and conditions of enrollment and to the Authorization to Obtain or Release Medical Information, which appears above and on the reverse side of this application.

 Applicant Signature: \_\_\_\_\_ Date \_\_\_\_\_ Spouse/Partner Signature (if applicable) \_\_\_\_\_ Date \_\_\_\_\_  
 If possible, please begin coverage on (choose month) \_\_\_\_\_ 1st. (Your application must be approved by the 20th of the month to be effective the 1st of the following month.)

I asked the applicant all the questions in this application and the answers are recorded as given to me.

Writing Agent Name (print) \_\_\_\_\_ Writing Agent Signature \_\_\_\_\_ Physicians Plus Agent # \_\_\_\_\_ Date \_\_\_\_\_

**6. For Health Plan Use Only**

Group #	Effective Date	Check #	Check Amount
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