EPIC BENEFITS+ ENROLLMENT FORM

Underwritten by The EPIC Life Insurance Company

Please print clearly or type - Submit completed form to your payroll/benefits office

Section 1: Applicant Information

Applicant name (last, first, middle)			Spouse/Domestic Partner Name (last, first, middle)
Street address (street, city, state, zip code)			
Daytime Telephone Number ( )	Date of Birth *(MM/DD/CCYY)*	Gender ☐ Male ☐ Female	Social Security number/EPIC Benefits+ ID No.

Section 2: Enrollment Information – ***Limited Term Employees must complete six months of WRS employment before enrolling.***

Reason for Application (Check one):	☐ New Hire ☐ Transfer ☐ Coverage Change ☐ Approved Enrollment Period ☐ Spouse to Spouse or Domestic Partner to Domestic Partner Coverage Transfer ☐ Cancel Coverage ☐ Address Change ☐ Name Change ☐ Beneficiary Change
Plan (check one):	☐ Without Vision Insurance ☐ With Vision Insurance
Coverage Level:	☐ Employee ☐ Employee + Spouse/Domestic Partner ☐ Employee + Child ☐ Family

Section 3: List Spouse/Domestic Partner/Child(ren) to be enrolled (use additional paper if needed to list all dependents)

Name	Date of Birth *(MM/DD/CCYY)*	Gender (M/F)	Social Security Number	Relationship to Applicant	Disabled (Y/N)	Tax Dep (Y/N)	Married (Y/N)
Beneficiary: Last Name	First Name		Middle Initial			Relationship	

Section 4: Change/Add/Cancel Current Coverage

Subscriber Name Change to:			
Add/Change Coverage Due to: *(list dependents you are adding in Section 3)*	**Date**	**Cancel/Change Coverage Due to:** *(list dependents you are deleting in Section 3)*	**Date**
☐ Marriage		☐ Divorce/Termination of Domestic Partnership	
☐ Domestic Partnership Established		☐ Death of Spouse/Partner/Child	
☐ Addition of Children (qualifying event)		☐ Loss of Dependent Eligibility	
☐ **Other Change:**	**Explanation if Needed:**		

Section 5: Information about Other Coverage (complete for all family members enrolling)

I have the following group insurance or had the following group insurance immediately prior to the anticipated effective date of this coverage: ☐ State of Wisconsin Group Health Insurance Name of Health Plan: ______________________________

☐ Other Insurance: Type of coverage: ☐ Health ☐ Dental Name(s) of All Other Plan(s): ___________________________________

My dependent(s) has other group coverage through an employer or had the following group insurance immediately prior to the anticipated effective date of this coverage: ☐ Yes ☐ No If yes, name of dependent(s): ________________________

☐ State of Wisconsin Group Health Insurance Name of Health Plan: ______________________________

☐ Other Insurance: Type of coverage: ☐ Health ☐ Dental Name(s) of All Other Plan(s): __________________________________

Section 6: Signature – (*Sign here and return completed application to your employer)*

☐ I apply for the coverage elected above. I understand that Wis. Stats. §943.395 provides criminal penalties for knowingly making false or fraudulent claims on this form and hereby certify that, to the best of my knowledge and belief, the information is true and correct. I agree to the provisions of the plan and hereby authorize deduction of the monthly premium from my salary. I understand that once enrolled this coverage must remain in force for the full calendar year unless eligibility is lost.

☐ I do not wish to enroll at this time.

☐ Cancel my coverage as of December 31, ___. I understand that I must submit the application to cancel coverage by December 1 or coverage will remain in force for the following calendar year unless eligibility is lost.

Applicant Signature X	Date *(MM/DD/CCYY)*

For Office Use only

Date Rec'd	**Received by**	**Hire Date**	**Cov Eff Date**	**Agency/Campus Code**	**Ded. Code – UW only** 404
Affidavit of domestic partnership on file ☐ N/A ☐ ETF Affidavit ☐ Non "Chapter 40" Affidavit				**Premium** $	**Employee ID – UW Only**