EPIC SPECIALTY BENEFITS

EPIC BENEFITS+ ENROLLMENT FORM

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

SECTION 1: APPLICANT INFORMATION

Please provide your legal name, your spouse's name, your complete address where you want all your mail to be delivered, a daytime telephone number where you can be reached or a message can be left, date of birth, gender, and social security number or your current EPIC Benefits+ customer number. This information ensures accurate and timely enrollment.

Applicant Name (last, first, middle)		Spouse Name (last, first, middle)		
Street Address		City	State	Zip Code
Social Security Number or EPIC Benefits+ ID Number	Email Address	Daytime Telephone Number	Date of Birth (MM/DD/YY)	Gender ☐ Male ☐ Female

SECTION 2: ENROLLMENT INFORMATION

Reason for Application (Check One):

☐ New Hire ☐ Coverage Change ☐ Spouse to Spouse Coverage Transfer ☐ Name Change

☐ Transfer ☐ Address Change ☐ Beneficiary Change

If you elect Vision, all dependents under your Benefits+ plan are also covered for Vision – you may not elect Vision for one member and not another within one plan.

Plan (Check One): ☐ With Vision Insurance ☐ Without Vision Insurance

Coverage Level: ☐ Employee ☐ Employee + Child(ren) ☐ Employee + Spouse ☐ Family

SECTION 3: LIST SPOUSE/CHILD(REN) TO BE ENROLLED

(Use additional paper if needed to list all dependents or designating beneficiary)

Please list all eligible dependents that you wish to have covered under your plan, accurate information insures claims to be processed timely. **Dependent children are eligible until the end of the month in which they turn 26.**

Listing a beneficiary is necessary to pay an Accidental Death and Dismemberment claim to your designated beneficiary. Beneficiary Designation form maybe downloaded from EPIC's website. Please send this designation form to EPIC at www.epicbenefits.com/wi-state-employees.

If enrolling one dependent but dropping another, please complete two applications and staple them together.

Name	**Date of Birth** (MM/DD/YY)	**Gender** (M/F)	**Social Security Number**	**Relationship to Applicant**	**Disabled** (Y/N)	**Tax Dep** (Y/N)
		☐ M ☐ F			☐ Y ☐ N	☐ Y ☐ N
		☐ M ☐ F			☐ Y ☐ N	☐ Y ☐ N
		☐ M ☐ F			☐ Y ☐ N	☐ Y ☐ N

Beneficiary:	Last Name	First Name	Middle Initial	Relationship	Percentage

Underwritten by The EPIC Life Insurance Company

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 canceling in Section 3)*	**Date**
☐ Marriage		☐ Divorce	
☐ Death of Spouse/Partner/Child		☐ Loss of Dependent Eligibility	
☐ Addition of Children			
☐ **Other Change:**		**Explanation if Needed:**	

SECTION 5: SIGNATURE – (Sign here and return completed application to your employer)

Please indicate if you are applying for coverage or if you are going to cancel your existing Benefits+ coverage.

Your signature and date are required to indicate that you are making a choice and that if electing coverage, you are authorizing payments to be deducted from your pay check.

☐ **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	**Date**
_____	_____

FOR OFFICE USE ONLY

Date Rec'd	**Received by**	**Hire Date**	**Cov Eff Date**	**Agency/Campus Code**
EPIC Group No.		**Division No.**		**Premium** $ _____

NOTE: RETURN THIS APPLICATION TO YOUR HUMAN RESOURCES DEPARTMENT.