3PADMINISTRATORS

P.O. Box 247 Onalaska, WI 54650 Ph: 608-779-3000 Fax: 608-779-3009

EMPLOYER GROUP: **MILLIS TRANSFER, INC.**

For Office Use Only
Effective: _____
Group ID:_____

EMPLOYEE INFORMATION

Last Name:	First Name:	MI:	
Date of birth:	Sex: M ☐ F ☐	Date of Employment:	Position:
Marital Status: Single ☐ Married ☐ Divorced ☐ Widow ☐		SSN:	Hours Per Week:
Current address:			Phone:
City:	State:	Zip:	Email Address:

Select Your Coverage(s): Single Medical $1,500 Deductible HSA ☐ Family Medical $3,000 Deductible HSA ☐
Single Dental ☐ Family Dental ☐ Single Vision ☐ Family Vision ☐

Wisconsin Employees Select Your Provider Network: Gundersen Healthcare ☐ Healtheos ☐

DEPENDENT INFORMATION

Dependents to be covered: (Include last name if different from employee's)

Spouse:	SSN:	Date of Birth:	Sex: M☐ F☐
Child 1:	SSN:	Date of Birth:	Sex: M☐ F☐
Child 2:	SSN:	Date of Birth:	Sex: M☐ F☐
Child 3:	SSN:	Date of Birth:	Sex: M☐ F☐
Child 4:	SSN:	Date of Birth:	Sex: M☐ F☐
Child 5:	SSN:	Date of Birth:	Sex: M☐ F☐

OTHER COVERAGES

As of your effective date, will there be any other group insurance coverage in effect on you or your covered dependents? Yes ☐ No ☐

If Yes, give name of **Employer** providing coverage: _____Name of **Primary Insured:**_____

Other medical coverage is: Single ☐ Family ☐	Other dental coverage: Single ☐ Family ☐	Other vision coverage: Single ☐ Family ☐	Family Members covered under other insurance:

MEDICAL HISTORY

Have you or any dependent to be covered incurred medical expense in excess of $25,000 during the last 12 months? Yes ☐ No ☐
If Yes, list the name of the person, the condition and degree of recovery:_____
_____

Are you or any covered dependent totally disabled? Yes ☐ No ☐

WAIVER OF BENEFITS

I, the undersigned, an employee of the above named policy holder, hereby certify that I have been given an opportunity to apply for group insurance benefits as offered by my employer and after careful consideration, I hereby waive my right to:

Single Medical ☐ Family Medical ☐ Single Dental ☐ Family Dental ☐
Single Vision ☐ Family Vision ☐

Reason for waiving coverage:_____

MEDICAL RELEASE AUTHORIZATION

By signing this form, I authorize release and disclosure of protected health information (PHI) to 3PAdministrators necessary for benefit determination, payment, treatment, or plan operations. PHI includes, but is not limited to, hospital records, physician records, lab results, mental health records, alcohol and/or drug abuse records and HIV testing. 3PA will not further release or disclose PHI received except to reinsurance carriers or as lawfully required. For additional information on any possible release or disclosure, I understand that I can request a copy of 3PAdministrators' privacy policy. 3PA will use PHI only for appropriate and accurate determination of medical benefits.

I further authorize 3PAdministrators to pay benefits directly to health care providers unless otherwise indicated.
I agree that this authorization is valid for one year from the signature date.
I may revoke this authorization by submitting a written request.

I hereby verify that the information listed above is true and accurate to the best of my knowledge.

Signature of Employee (Required):_____Date Signed:_____

IMPORTANT INFORMATION ON YOUR RIGHTS AND RESPONSIBILITIES

Special Enrollment Provision

Loss of other coverage. If you decline coverage for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

New dependent. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact your employer's human resource department.

Women's Health and Cancer Rights Act Notice

On October 21, 1998, the federal government passed the Women's Health and Cancer Rights Act of 1998. As part of our plan's compliance with this Act, we are required to provide you, at the time of enrollment, with information outlining the coverage this law requires our plan to include.

Our group health plan has always provided coverage for medically necessary mastectomies. This coverage includes procedures to reconstruct the breast on which the mastectomy was performed, as well as the cost of necessary prostheses (implants, special bras, etc.) and treatment of any physical complications resulting from any stage of the mastectomy. However, as a result of this federal law, the plan now provides coverage for surgery and reconstruction of the other breast to achieve a symmetrical appearance with the breast on which the mastectomy is performed.

The following benefits are required to be provided if benefits are provided for a mastectomy:

1. Coverage for reconstruction of the breast on which the mastectomy is performed.
2. Coverage for surgery and reconstruction of the other breast to produce a symmetrical appearance with the breast on which the mastectomy is performed.
3. Coverage for prostheses and physical complications resulting for any state of the mastectomy, including lymphedemas.

These benefits are subject to the same deductible, co-pays and co-insurance that apply to mastectomy benefits under the plan.

Spousal Carve-out

Spousal Carve-out occurs when the spouse of an employee is entitled to group coverage with their own employer. The spouse is not eligible for coverage under this plan whether or not he or she enrolls in the plan available to them. Spousal carve-out does not require that dependent children must be enrolled in the spouse's employer sponsored plan. This provision applies to all employees.

DEPENDENT INFORMATION QUESTIONNAIRE

In order to finish the enrollment process for your dependents, this questionnaire **MUST BE** completed. If there is a court order or divorce decree that applies to any dependents, you must include a copy with the completed form.

Dependents **WILL NOT** be enrolled without this information.

Please include only dependents for whom you are requesting coverage.

Spouse's Name:______________________________ Date of Birth:____________________

Spouse's Employer:____

Spouse's Employer offers: Health Insurance ☐ Yes ☐ No Dental Insurance ☐ Yes ☐ No
Vision Insurance ☐ Yes ☐ No

Child's Name:______________________________ Date of Birth:____________________

Child's Residence Address:____

Child Has Resided Here Since:____________________ Child is: ☐ Single ☐ Married

Child is: ☐ My natural child ☐ My stepchild ☐ My adopted child ☐ Grandchild ☐ I am legal guardian

Do you provide at least 50% support for this child? ☐ Yes ☐ No
Do you claim this child on federal income tax? ☐ Yes ☐ No
Is there a court decree for: Insurance coverage? ☐ Yes ☐ No Financial support? ☐ Yes ☐ No
(If yes to either, include a copy with this form)

Child's Name:______________________________ Date of Birth:____________________

Child's Residence Address:____

Child Has Resided Here Since:____________________ Child is: ☐ Single ☐ Married

Child is: ☐ My natural child ☐ My stepchild ☐ My adopted child ☐ Grandchild ☐ I am legal guardian

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Is there a court decree for: Insurance coverage? ☐ Yes ☐ No Financial support? ☐ Yes ☐ No
(If yes to either, include a copy with this form)

I hereby verify that the information listed above is true and accurate to the best of my knowledge.

______________________________ ____________________
Employee Signature Date

3PAdministrators
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Fax: 877-540-0094