

2023 Direct Individual & Family Policy Application Worksheet

Agent/Office Use Only

Agency Name/Code	PCP Location
Writing Agent's Name	Effective Date

Please complete this entire application in ink.

The application process requires you to complete all of the following:

- **Individual Policy Application Worksheet, Applicant Information, Terms and Conditions, and Form A**

- **Select One of the Payment Methods for First Month's Premium**
 - Automatic Transfer of Funds** (Form B required)
 - Personal Check** (Required with application if paying by check)

Coplay Plus & Copay Elite Plan Options	Deductible Individual / Family	Coinsurance	Max Out-of-Pocket Individual / Family	Focus Network Option
Gold Copay Plus 1550 <input type="checkbox"/>	\$1,550 / \$3,100	20%	\$5,700 / \$11,400	<input type="checkbox"/> Yes / <input type="checkbox"/> No
Silver Copay Plus 4850 <input type="checkbox"/>	\$4,850 / \$9,700	30%	\$9,100 / \$18,200	<input type="checkbox"/> Yes / <input type="checkbox"/> No
Bronze Copay Plus 9100 <input type="checkbox"/>	\$9,100 / \$18,200	0%	\$9,100 / \$18,200	<input type="checkbox"/> Yes / <input type="checkbox"/> No
Gold Copay Elite 1550* <input type="checkbox"/>	\$1,550 / \$3,100	20%	\$5,700 / \$11,400	N/A
Silver Copay Elite 4850* <input type="checkbox"/>	\$4,850 / \$9,700	30%	\$9,100 / \$18,200	N/A

Coplay Plus & Copay Elite Prescription Drug Benefits – Gold & Silver offer \$15 Generics, \$60 Preferred Brand, 50% Non-Preferred Brand, 50% Specialty
Bronze offers \$20 Generics and no charge after deductible on all other tiers

* **Coplay Elite plans are only available to residents in Dodge, Green Lake, Iowa & Jefferson counties**

Value Copay Plan Options	Deductible Individual / Family	Coinsurance	Max Out-of-Pocket Individual / Family	Focus Network Option
Gold Value Copay 4050 <input type="checkbox"/>	\$4,050 / \$8,100	0%	\$4,050 / \$8,100	<input type="checkbox"/> Yes / <input type="checkbox"/> No
Silver Value Copay 4150 <input type="checkbox"/>	\$4,150 / \$8,300	30%	\$8,700 / \$17,400	<input type="checkbox"/> Yes / <input type="checkbox"/> No
Bronze Value Copay 9100 <input type="checkbox"/>	\$9,100 / \$18,200	0%	\$9,100 / \$18,200	<input type="checkbox"/> Yes / <input type="checkbox"/> No

Value Copay Prescription Drug Benefits – Gold & Silver offer \$15 Generics, 50% Preferred Brand, 50% Non-Preferred Brand, 50% Specialty
Bronze offers no charge after deductible on all tiers

HSA Eligible Plan Options	Deductible Individual / Family	Coinsurance	Max Out-of-Pocket Individual / Family	Focus Network Option
Gold HSA HDHP 2050 <input type="checkbox"/>	\$2,050 / \$4,100	20%	\$4,500 / \$9,000	<input type="checkbox"/> Yes / <input type="checkbox"/> No
Silver HSA-E HDHP 3600 <input type="checkbox"/>	\$3,600 / \$7,200	20%	\$7,050 / \$14,100	<input type="checkbox"/> Yes / <input type="checkbox"/> No
Bronze HSA-E HDHP 7050 <input type="checkbox"/>	\$7,050 / \$14,100	0%	\$7,050 / \$14,100	<input type="checkbox"/> Yes / <input type="checkbox"/> No

HSA Eligible Prescription Drug Benefits – Policy coinsurance after deductible on all tiers

Requested Effective Date

m m / d d / y y y y

The Affordable Care Act offers specific effective dates for each enrollment situation. Please visit deancare.com for more information.

Please indicate the reason for submitting this application:

Open Enrollment

Special Enrollment* (qualifying event and date required)

Qualifying Event _____

Event Date m m / d d / y y y y
*May require documentation

Applicant Information

Step 1 Tell us about yourself.

(We'll need one adult, age 18 or older, to be the contact person for your application and billing information.)

1) First name, Middle name, Last name, & Suffix			
2) Home address			3) Apartment or suite number
4) City	5) State	6) ZIP code	7) County
8) Mailing address (if different from home address)			9) Apartment or suite number
10) City	11) State	12) ZIP code	13) County
14) Phone Number () -		15) Other Phone Number () -	
16) Do you want to get information about this application by email? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Email address _____			
17) Preferred spoken or written language (if not English)			
18) Do you need health coverage for yourself? <input type="checkbox"/> Yes. If yes , answer all the questions below. <input type="checkbox"/> No. If no , skip to Question 23.			
19) Social Security number ____ - ____ - _____			
20) Sex <input type="checkbox"/> Male <input type="checkbox"/> Female			
21) Date of birth (mm/dd/yyyy) ____ / ____ / _____			
22) Do you use tobacco? (required if age 21 or older) <input type="checkbox"/> Yes <input type="checkbox"/> No			
Tobacco use is defined as use of tobacco on average of four or more times per week in the past six months, unless for ceremonial or religious purposes.			
23) Is there an authorized representative for someone other than your minor dependent(s) listed on this application? (requires legal documentation as proof)		<input type="checkbox"/> Yes. If yes , please enter name and select a relationship below: Authorized Representative _____ <input type="checkbox"/> Guardian or other court-appointed role <input type="checkbox"/> Power of attorney <input type="checkbox"/> Other (please specify) _____	
24) Does anyone applying for coverage currently have health insurance?		<input type="checkbox"/> Yes. If yes , please fill in your insurance information below: Current Insurance Provider _____ Member ID Number(s) _____	

Special Enrollment – If you are applying for coverage under the Special Enrollment rule **AND** you answered YES to Question 24, **you must enter applicant information for every individual who will be covered under the policy.**

Now, tell us who else needs health coverage. ►

 **NEED HELP WITH YOUR APPLICATION?** Visit deancare.com or call us at **(800) 279-1302**. If you need help in a language other than English, call **(800) 279-1302** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY: **711**.

Step 2 Tell us about anyone else who needs health coverage.

(If you have more people to include, make a copy of this page and attach.)

Person 2

1) First name, Middle name, Last name, & Suffix		2) Relationship to you
3) Social Security number ____ - ____ - _____	4) Date of birth (mm/dd/yyyy) ____ / ____ / _____	5) Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
6) Does Person 2 live at the same address as you? <input type="checkbox"/> Yes <input type="checkbox"/> No If no , list address below.		
7) Does Person 2 use tobacco? (required if age 21 or older) <input type="checkbox"/> Yes <input type="checkbox"/> No		

Tobacco use is defined as use of tobacco on average of four or more times per week in the past six months, unless for ceremonial or religious purposes.

Person 3

1) First name, Middle name, Last name, & Suffix		2) Relationship to you
3) Social Security number ____ - ____ - _____	4) Date of birth (mm/dd/yyyy) ____ / ____ / _____	5) Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
6) Does Person 3 live at the same address as you? <input type="checkbox"/> Yes <input type="checkbox"/> No If no , list address below.		
7) Does Person 3 use tobacco? (required if age 21 or older) <input type="checkbox"/> Yes <input type="checkbox"/> No		

Tobacco use is defined as use of tobacco on average of four or more times per week in the past six months, unless for ceremonial or religious purposes.

Person 4

1) First name, Middle name, Last name, & Suffix		2) Relationship to you
3) Social Security number ____ - ____ - _____	4) Date of birth (mm/dd/yyyy) ____ / ____ / _____	5) Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
6) Does Person 4 live at the same address as you? <input type="checkbox"/> Yes <input type="checkbox"/> No If no , list address below.		
7) Does Person 4 use tobacco? (required if age 21 or older) <input type="checkbox"/> Yes <input type="checkbox"/> No		

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Step 3 Read the Terms and Conditions and sign the Application

Application Terms and Conditions

1. By signing this Application, I understand and agree that: (a) All statements and answers I have given are complete and true to the best of my knowledge and belief; (b) the insurance I hereby apply for will be effective only when Dean Health Plan, Inc. (DHP) approves this Application. Evidence of such approval will be issuance of ID card(s) and policy. The effective date will be the date shown on the I.D. card issued; (c) the Social Security numbers I have provided may be used for I.D. purposes; and (d) if my or my dependents' information has changed from what is indicated on the Application prior to the effective date of coverage, I will notify DHP of the change immediately.
2. I further understand that my information on this form will only be used to determine eligibility for health coverage and will be kept private as required by law.
3. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an Application for insurance is guilty of a crime and may be subject to fines and/or imprisonment or subject to other penalties under law. I further understand that, in the event of fraud or intentional misrepresentation, claims may be denied in whole, or in part, and coverage may be rescinded.
4. I also understand that a medical provider, medical facility or pharmacy benefit manager that provides treatment or service to me, my spouse and dependents covered under this Application, may generally disclose information relevant to that treatment/service to DHP or its representatives after my/our enrollment begins. Such information may be used for the purposes of claims adjudication, quality assurance, quality improvement, care management and other activities according to the insurer's Notice of Privacy of Practices, which is available at deancare.com.
5. All statements and answers in this Application are representations made by me on behalf of myself and other persons named in the Application, if any, to induce the issuance of the policy applied for. The contents of this Application are to be solely relied upon by the insurer.
6. I, the undersigned, on behalf of myself and my dependents, if any, named in this Application, agree to cooperate in providing DHP with any information needed to process this Application.
7. This Application, when approved, and any endorsement, forms, amendment or rider thereto, will be made part of the policy applied for.
8. I understand that an insurance agent or broker cannot modify, waive or change in any way this Application, any requirement imposed by the insurer, nor bind coverage or guarantee approval of this Application. No person, except an officer of the insurer, is authorized to vary or modify a policy or contract. I further understand and agree that the insurer, its directors, officers, employees, and agents shall not be liable for any injury, damage or expense (including attorney's fees) that I or any of my dependents suffer as a result of any improper advice, action or omission on the part of any health care provider.

Signature of Applicant

Date (mm/dd/yyyy)

Signature of Spouse/Domestic Partner

Date (mm/dd/yyyy)

Signature(s) of Adult Children Age 18 or Older

Date (mm/dd/yyyy)

Notice To Applicant Regarding Replacement of Accident/Sickness Insurance (Form A)



This Policy provides ten (10) days within which you can decide, at no cost to you, whether you desire to keep this Policy.

If you intend to lapse or otherwise terminate your present policy and replace it with a Policy issued by Dean Health Plan, Inc. (DHP), the following facts should be considered before you make this change:

1. You may have health conditions covered under your present policy that may not be covered under the new Policy. This could result in the denial of future benefit claims relating to these health conditions under the new Policy.
2. Questions in the Application for the new Policy must be answered truthfully and completely; otherwise, the validity of the new Policy, and the payment of any benefits thereunder, may be voided.
3. The new Policy will be issued at a higher age than that used for issuance of your present policy; therefore, the cost of the new Policy, depending upon the benefits, may be higher than you are paying for your present policy.
4. The renewal provisions of the new Policy should be reviewed, as they may differ from your present policy.

It may be to your advantage to secure the advice of your present insurer, or its agent, regarding the proposed replacement of your present policy. You should be certain that you understand all the relevant factors involved in replacing your present coverage.

The above "Notice to Applicant" was delivered to me on _____
Date (mm/dd/yyyy)

Signature of Applicant

Authorization for Automatic Transfer of Funds (Form B)



Dean Health Plan, Inc. offers an easy way to make monthly premium payments, called the **Direct Premium Payment Program**. This service allows Dean Health Plan to automatically transfer funds from your checking or savings account on a monthly basis to pay your monthly premiums. This program ensures your monthly premiums will be paid timely even if you are traveling and there is no cost to you for this service.

To participate, simply sign this authorization and attach a voided check that shows the bank and account number. Please be sure to fill in your financial institution name, routing number and account number below. We will take care of the rest!

The Direct Premium Payment Program will generally start on the 23rd of the month following acceptance of your application. You will receive a letter prior to the first transfer notifying you of the amount that will be transferred from your account and when the first transfer will occur. Thereafter, your monthly premium will be transferred from your account on the 23rd of each month or the business day following. Any transactions that are not possible due to insufficient funds will be your responsibility.

If you have any questions, please contact the Customer Care Center at (800) 279-1302, TTY users dial 711, Monday through Thursday 7:30 a.m. to 5:00 p.m. and Friday from 8:00 a.m. to 4:30 p.m. Form B can be submitted along with your application or mailed direct to Dean Health Plan Enrollment Department, 1277 Deming Way, Madison, WI 53717.

By the Authorized Bank Account Holder signature below, I authorize Dean Health Plan to instruct my financial institution to deduct my premium payments from the account designated below. I authorize the financial institution to debit the amount of my premium from my designated account. This authorization is to remain in full force and in effect until Dean Health Plan has received written notification from the individual member of their termination in such time and in such manner as to afford Dean Health Plan and the financial institution a reasonable opportunity to act on it.

Name of Account Holder (please print)	Name of Financial Institution																	
Routing number	<table border="1" style="display: inline-table; border-collapse: collapse; text-align: center;"> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> </table>																	
Account number	<table border="1" style="display: inline-table; border-collapse: collapse; text-align: center;"> <tr><td style="width: 20px; height: 20px;"></td><td style="width: 20px; height: 20px;"></td></tr> </table>																	
	Type <input type="checkbox"/> Checking <input type="checkbox"/> Savings																	

Signature of Authorized Bank Account Holder	Date (mm/dd/yyyy)
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