Senate Committee on Agriculture, Financial Institutions and Insurance
Room 18 South State Capitol, PO Box 7882, Madison WI 53707-7882
(608) 266-0703
Senator Dale W. Schultz, Chairman

Monday, November 10, 2003

Members
Senate Committee on Agriculture
Financial Institutions
& Insurance

The following clearinghouse rule was referred to the Senate Committee on Agriculture Financial Institutions and Insurance. The thirty-day review period began on October 29th, 2003.

Clearinghouse Rule 03-055,To create Ins 8.49, Wis. Adm. Code, relating to Small Employer Uniform Employee Application.

A hard copy of the rule is attached. The text is also available online in the FOLIO Clearinghouse Rules infobase.

The last business day for action on this rule is **Friday November 28th, 2003**.

If you have concerns or questions related to this rule, please contact John in my office (6-0703) with any questions, or to request the committee hold a hearing on this rule.

Thank you.

Senator Dale Schultz
Chairman

Clearinghouse Rule 03-055

Rule Sent to Clearinghouse

PROPOSED ORDER OF THE OFFICE OF THE COMMISSIONER OF INSURANCE

CREATING A RULE

To create Ins 8.49, Wis. Adm. Code, relating to Small Employer Uniform Employee Application.

ANALYSIS PREPARED BY THE OFFICE OF THE COMMISSIONER OF INSURANCE

Statutory authority: ss. 601.41(3), 601.41 (8), 635.10, Stats.

Statutes interpreted: ss. 635.10, Stats.

In accordance with s. 601.41 (8) and s. 635.10, Stats., the Office is statutorily required to develop a rule and the uniform employee application for group health insurance that is to be used by small employer insurers for small employer applicants. In compliance with s. 601.41(8), Stats., the Office, with consultation of the life and disability advisory council, convened a taskforce with representatives of small employers, licensed intermediaries and small employer insurers to obtain information relating to a proposed uniform employee application form. The taskforce made recommendations to the Office for its consideration in the development of the small employer uniform employee application.

The intent of the legislation was two-fold; to reduce the number of forms employees were required to complete when a small employer applied for group health insurance and permits small employers to seek multiple premiums from different

small employer insurers with one form. Having a uniform employee application that could be used to obtain multiple premiums also has the benefit of decreasing the amount of time spent by the small employer in obtaining the premium information since the form may be photocopied and submitted simultaneously to several insurers.

To address the concerns of the small employers, licensed intermediaries and small employer insurers, the Office, in addition to drafting the uniform employee application, also drafted the rule governing the use and management of the application process. The proposed regulations establishes the following: photocopies of the form shall be accepted as though it were an original; duration for use of the information contained within the application form; and, requires small employer insurers to share the photocopied forms, in accordance with the applicant's authorization, with other named insurers within 5 business days as requested in writing by the small employer. The intent is to facilitate a timely exchange of the applications so that the small employer is able to receive the premium amount necessary to make an informed decision regarding the purchase of group health insurance.

Finally, although the uniform application will be available for use beginning August 1, 2003, in accordance with the statute, the rule permits a 60 day grace period to enable small employer insurers to transition from their individual application forms to the uniform application.

SECTION 1. Section Ins 8.49 is created to read:

Ins 8.49 Uniform employee application. (1) (a) In accordance with s. 635.10, Stats., small employer insurers shall implement procedures and policies

necessary to use the small employer uniform employee application, that is available beginning August 1, 2003, no later than the effective date of this rule.

(b) Small employer insurers shall treat and accept a photocopy of the uniform employee application as an original.

Note: A copy of the uniform employee application form OCI 26-501 (c 08/2003), required in par. (a), may be obtained from the Office of the Commissioner of Insurance, P.O. Box 7873, Madison WI 53707-7873, Web Address: oci.wi.gov.

(2) (a) The information contained within the uniform employee application shall be considered current information by the small employer insurer if the information is received by the small employer insurer within 30 days of completion of the most recent signed uniform employee application form. The small employer insurer may accept and utilize information provided by an employee subsequent to the date the employee signed the application if the employee is providing the insurer with additional or modified information than was contained within the uniform employee application that was received by the small employer insurer within 30 days of the last signed application.

(b) A small employer insurer may require the small employer to complete new uniform employee applications if either of the following occur:

1. The authorization signed by the employee does not include the name of the small employer insurer that the small employer is requesting provide the small employer with a premium.

2. The uniform employee applications are received by the small employer insurer more than 30 days after the date of the last signed uniform employee application.

(3) (a) Small employer insurers that receive a written request from a small employer to forward a copy of the completed uniform employee applications to a different small employer insurer listed within the authorization section of the application shall forward photocopies of the uniform employee applications within 5 business days from receipt of the request. The small employer insurer shall notify the employer, as soon as practicable, by telephone or written communication, if it is unable to comply with the request because the small employer has requested information be sent to a small employer insurer not identified within the authorization.

(b) If the small employer uses the services of a licensed intermediary to assist in obtaining premium information utilizing the uniform employee application, the intermediary shall forward, within 5 business days from receipt of the applications, copies of the uniform employee applications to all small employer insurers identified within the uniform employee application authorization to receive the applications, or to an authorized intermediary of each small employer insurer. The intermediary may withhold distribution to some or all authorized small employer insurers, or the insurer's authorized representative, at the request of the small employer.

(c) Uniform employee applications shall be maintained by small employer insurers and licensed intermediaries in accordance with subch. V of ch. Ins 25.

(4) (a) Small employer insurers shall state the premium to the small employer within 5 business days from receipt of all pertinent information required for its underwriting of the small employer's application materials for group health insurance, including completed uniform employee applications.

(b) Small employer insurers shall make a reasonable effort to obtain the required information described in par. (a).

SECTION 2. This rule shall take effect on the first day of the third month following publication in the Wisconsin administrative register as provided in s. 227.22(2)(intro.), Stats.

Dated at Madison, Wisconsin, this _____ day of _____, 2003.

_____

Jorge Gomez
Commissioner of Insurance

Wisconsin Department of Administration
Division of Executive Budget and Finance
DOA-2047 (R10/2000)

FISCAL ESTIMATE WORKSHEET — 2001 Session

Detailed Estimate of Annual Fiscal Effect

☒ ORIGINAL	☐ UPDATED	LRB Number	Amendment No. if Applicable
☐ CORRECTED	☐ SUPPLEMENTAL	Bill Number	Administrative Rule Number **INS 8.49**

Subject
Small Employer Uniform Employee Application

One-time Costs or Revenue Impacts for State and/or Local Government (do not include in annualized fiscal effect):
None

Annualized Costs:	Annualized Fiscal impact on State funds from: Increased Costs	Decreased Costs
A. State Costs by Category State Operations - Salaries and Fringes	$ 0	$ -0
(FTE Position Changes)	(0 FTE)	(-0 FTE)
State Operations - Other Costs	0	-0
Local Assistance	0	-0
Aids to Individuals or Organizations	0	-0
TOTAL State Costs by Category	$ 0	$ -0
B. State Costs by Source of Funds	**Increased Costs**	**Decreased Costs**
GPR	$ 0	$ -0
FED	0	-0
PRO/PRS	0	-0
SEG/SEG-S	0	-0
C. State Revenues Complete this only when proposal will increase or decrease state revenues (e.g., tax increase, decrease in license fee, etc.)	**Increased Rev.**	**Decreased Rev.**
GPR Taxes	$ 0	$ -0
GPR Earned	0	-0
FED	0	-0
PRO/PRS	0	-0
SEG/SEG-S	0	-0
TOTAL State Revenues	$ 0 None	$ -0 None

NET ANNUALIZED FISCAL IMPACT

	STATE	LOCAL
NET CHANGE IN COSTS	$ None 0	$ None 0
NET CHANGE IN REVENUES	$ None 0	$ None 0

Prepared by:	Telephone No.	Agency
Julie E. Walsh	(608) 264-8101	Insurance
Authorized Signature:	**Telephone No.**	**Date** (mm/dd/ccyy)

Wisconsin Department of Administration
Division of Executive Budget and Finance
DOA-2048 (R10/2000)

FISCAL ESTIMATE — 2001 Session

☒ ORIGINAL	☐ UPDATED	LRB Number	Amendment No. if Applicable
☐ CORRECTED	☐ SUPPLEMENTAL	Bill Number	Administrative Rule Number **INS 8.49**

Subject
Small Employer Uniform Employee Application

Fiscal Effect

State: ☒ No State Fiscal Effect

Check columns below only if bill makes a direct appropriation or affects a sum sufficient appropriation.

☐ Increase Existing Appropriation ☐ Increase Existing Revenues
☐ Decrease Existing Appropriation ☐ Decrease Existing Revenues
☐ Create New Appropriation

☐ Increase Costs - May be possible to Absorb Within Agency's Budget ☐ Yes ☐ No

☐ Decrease Costs

Local: ☒ No local government costs

1. ☐ Increase Costs ☐ Permissive ☐ Mandatory
2. ☐ Decrease Costs ☐ Permissive ☐ Mandatory
3. ☐ Increase Revenues ☐ Permissive ☐ Mandatory
4. ☐ Decrease Revenues ☐ Permissive ☐ Mandatory
5. Types of Local Governmental Units Affected: ☐ Towns ☐ Villages ☐ Cities ☐ Counties ☐ Others _____ ☐ School Districts ☐ WTCS Districts

Fund Sources Affected
☐ GPR ☐ FED ☐ PRO ☐ PRS ☐ SEG ☐ SEG-S

Affected Chapter 20 Appropriations

Assumptions Used in Arriving at Fiscal Estimate

The proposed rule provides the guidelines for utilizing the small employer uniform application. The Office is required to review the form on a bi-annual basis. There is no financial effect to the State or small employers. Rather, the utilization of the uniform small employee application is intended to save small employers money by utilizing one form for obtaining accurate premiums from multiple small employer insurers.

Long-Range Fiscal Implications

None

Prepared by:	Telephone No.	Agency
Julie E. Walsh	(608) 264-8101	Insurance
Authorized Signature:	**Telephone No.**	**Date** (mm/dd/ccyy)

SMALL EMPLOYER UNIFORM EMPLOYEE APPLICATION FOR GROUP HEALTH INSURANCE FORM

State of Wisconsin
Office of the Commissioner of Insurance
P.O. Box 7873
Madison, WI 53707-7873
(608) 266-3585
Web Address: oci.wi.gov

Ref: Section Ins 8.49, Wis. Adm. Code, and
Sections 601.41 (8), 635.10, Wis. Stat.

Pursuant to s. 635.10, Wis. Stat., every small employer insurer shall use the uniform employee application form when a small employer applies for coverage under a group health benefit plan offered by the small employer insurer. Section INS 8.49, Wis. Adm. Code, delineates the requirements for utilization, timing and maintaining the uniform application forms.

This form is designed for an employer's initial application for coverage. Please contact your agent or the insurer to determine if this form should be used in other situations once the group is enrolled with the insurer.

EMPLOYER INFORMATION – To be filled out by Employer

Employer Name **Group Number** **Division Number** **Employee Class**

Total Number of Permanent Employees Who Have a Normal Work Week of 30 or More Hours _____

Insurer: _____ **Insurer:** _____ **Insurer:** _____

I. EMPLOYEE INFORMATION

Employee Instructions: Please print using black ink. Please fill out the entire application for each person for whom coverage is being sought.

Employee's First Name, Middle Initial and Last Name: _____

Social Security No.: _____ Birth Date: _____ Sex: [ ] Male [ ] Female Height/Weight: _____

Mailing Address: _____

City: _____ County: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Email: _____
[ ] Home [ ] Work

1. For your current employer:

What was your first day of employment? ___/___/___ How many hours, on average, do you work each week? _____

What is your annual salary? _____

2. Are You:

a) [ ] Single [ ] Married [ ] Legally Separated [ ] Divorced [ ] Widow/Widower

If you are married, legally separated, divorced or widowed, please indicate the date that the event occurred: _____
If you are married, please indicate the county and state in which you were married: _____

b) A Retiree? [ ] Yes [ ] No

c) On COBRA or State Continuation? [ ]Yes [ ] No If yes, start date and reason _____

II. WAIVER OF COVERAGE

I understand that I am eligible to apply for group health insurance through my employer. I do **NOT** want, and hereby waive, group health insurance for (check the box that applies):

[ ] Waiving for the entire family [ ] Waiving for the spouse [ ] Waiving for dependent child(ren)

I am waiving group health insurance because (check all that apply):

[ ] I, the employee, am covered or will be covered under another plan that is not sponsored by my employer. I am **not** enrolled for coverage under the Health Insurance Risk-Sharing Plan (HIRSP). Please attach a copy of your identification card for that plan.

[ ] I, the employee, do not have a risk characteristic or other attribute that would be the sole cause for the small employer insurer to make a decision with respect to premiums or eligibility for a policy that is adverse to the small employer.

[ ] My spouse is covered or will be covered under another plan that is not sponsored by this employer. My spouse is **not** enrolled for coverage under the Health Insurance Risk-Sharing Plan (HIRSP). Please attach a copy of your spouse's identification card for that plan.

[ ] My dependent child(ren) is/are covered or will be covered under another plan that is not sponsored by my employer. My dependent child(ren) is/are **not** enrolled for coverage under the Health Insurance Risk-Sharing Plan (HIRSP). Please attach our identification card for that plan. Please list the name(s) of the child(ren) for whom coverage is being waived.

[ ] I am **not** enrolled under the Health Insurance Risk-Sharing Plan (HIRSP) and the annualized premium contribution to be paid by me on behalf of myself or my dependent spouse and/or child(ren) would exceed **10%** of my **annualized gross earnings**.

WAIVER: I certify that I have been given the opportunity to apply for group health insurance and decline to enroll as indicated above, on behalf of myself, my spouse and/or my dependent child(ren). I understand that by signing this waiver, I, my spouse, and/or my dependent child(ren) forfeit the right to coverage. I was not pressured nor forced by my employer, the agent or the insurer(s) into waiving/declining the group health insurance. If in the future I apply for coverage, I, my spouse, or any of my dependent child(ren) may be treated as a late enrollee and subject to an exclusion of coverage for preexisting conditions for a period of up to 18 months. This period may be offset by the time the person was covered under a qualified health plan.

I understand that if I am declining enrollment for myself, my spouse, or my dependent child(ren) because of other health insurance, I may in the future be able to enroll myself, my spouse, or my dependent child(ren) in this plan, provided that I request enrollment within 30 days after my other health coverage ends. In addition, if I gain a dependent spouse or child(ren) as a result of marriage, birth, adoption, or placement for adoption, I understand that I may be able to enroll myself, my spouse and/or my dependent child(ren), provided that I request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

Signature of Employee:_____ Date Signed:_____

Signature of Spouse:_____ Date Signed:_____

III. TYPE OF COVERAGE

a) Please select the type of coverage for which you are applying:

[ ] Employee Only [ ] Employee & Spouse [ ] Employee & Children [ ] Employee, Spouse & Children

IV. DEPENDENT INFORMATION

a) List all dependents, spouse and child(ren) applying for insurance. The form continues on the next page. If you need additional space, please use a separate sheet of paper and attach it to this application (please sign and date the additional sheet).

Name (First; M.I.; Last)	Sex	Social Security Number	Relationship	Birth Date (Mo/ Day/ Yr)	Height Weight	Full-Time Student (if over age 18)
			Spouse			

			[ ] Child [ ] Stepchild [ ] Grandchild			School _____ Graduation Date _____ Credits/Semester
			[ ] Child [ ] Stepchild [ ] Grandchild			School _____ Graduation Date _____ Credits/Semester

b) If required by the insurer, for the dependent children who are full-time students, do you provide at least 50% of the dependent's support? [ ] Yes [ ] No If not, which dependents do you not provide 50% support? _____

c) Do all dependent children applying for coverage live with you at the address shown above? [ ] Yes [ ] No. If not, please list name(s) and other address(es): _____

_____

d) Is anyone named in this application now disabled, mentally incompetent or unable to perform normal work or age-related activities? [ ] Yes [ ] No

If yes, please identify names, health conditions, dates of disability and names and addresses of attending physicians:

_____

_____

_____

V. MEDICARE INFORMATION

If you need to complete this Section V for more than one person, please use a separate sheet of paper and attach it to this application (please sign and date the additional sheet).

Are you, your spouse or your child(ren) covered by Medicare Part A and Part B? [ ] No [ ] Yes

Name of person covered by Medicare: _____

If Yes, reason for Medicare: [ ] Over Age 65 [ ] Disability [ ] End-Stage Renal Disease (ESRD) [ ] Disability and ESRD

Medicare Part A Effective Date: _____ Medicare Part B Effective Date _____

Medicare Part C (Medicare + Choice) Effective Date: _____

VI. MEDICAL INFORMATION

Please answer the following questions to the best of your knowledge. On the next page, please provide the complete details if you answer "yes" to any of the questions below. **You are required to promptly notify your employer so that you may provide updated information to the small employer insurer(s) of any changes or developments in your, or in any family member's, health history that occur prior to your receipt from your employer's that there has been an insurer's underwriting decision regarding this application.**

A. Are you, your spouse or any child(ren) (even if not listed on the application) currently pregnant or an expectant parent? (If yes, due date is _____) [ ] Yes [ ] No

B. Has anyone named in this application been treated or diagnosed by a medical professional as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? [ ] Yes [ ] No

C. Has anyone named in this application used tobacco or smokeless tobacco during the past 12 months? [ ] Yes [ ] No If yes, provide information as requested regarding the product, duration and frequency of use in section F below .

D. In the past 5 years has anyone named in this application:

1. Been evaluated or treated for alcoholism or chemical dependency; or joined any organization for alcoholism or chemical dependency; or used illegal drugs or been advised by a health care professional to reduce the use of alcohol or illegal drugs? [ ] Yes [ ] No

E. Within the last 10 years, has anyone named in this application been counseled, consulted or treated for any of the following (*please check all that apply*):

1. CIRCULATORY SYSTEM
- a) heart disease or disorder [ ] Yes [ ] No
- b) stroke [ ] Yes [ ] No
- c) circulatory disorder [ ] Yes [ ] No
- d) chest pain [ ] Yes [ ] No
- e) high or low blood pressure [ ] Yes [ ] No
- f) elevated cholesterol and/or triglyceride levels? [ ] Yes [ ] No
- g) anemia or blood disorder [ ] Yes [ ] No

2. DIGESTIVE SYSTEM
- a) ulcers [ ] Yes [ ] No
- b) stomach disorder [ ] Yes [ ] No
- c) liver/pancreas disorder [ ] Yes [ ] No
- d) gallbladder disorder [ ] Yes [ ] No
- e) intestinal disorder (e.g., colitis, Crohn's disease) [ ] Yes [ ] No
- f) hernia [ ] Yes [ ] No
- g) rectal disorder [ ] Yes [ ] No

3. GENITOURINARY SYSTEM
- a) menstrual disorder [ ] Yes [ ] No
- b) genital disorder [ ] Yes [ ] No
- c) sexual dysfunction [ ] Yes [ ] No
- d) pregnancy complications (e.g., premature birth, miscarriage, c-section) [ ] Yes [ ] No
- e) infertility [ ] Yes [ ] No
- f) urinary tract/kidney/bladder disorder [ ] Yes [ ] No
- g) prostrate disorder [ ] Yes [ ] No

4. ENDOCRINE SYSTEM
- a) diabetes [ ] Yes [ ] No
- b) thyroid disorder [ ] Yes [ ] No
- c) adrenal disorder [ ] Yes [ ] No
- d) enlargement of the lymph-nodes [ ] Yes [ ] No
- e) connective tissue disorder [ ] Yes [ ] No

5. RESPIRATORY SYSTEM
- a) allergy(ies) [ ] Yes [ ] No
- b) asthma [ ] Yes [ ] No
- c) emphysema [ ] Yes [ ] No
- d) sinus or nasal disorder [ ] Yes [ ] No
- e) lung disease or disorder [ ] Yes [ ] No
- f) shortness of breath [ ] Yes [ ] No

6. MUSCULAR/SKELETAL
- a) arthritis [ ] Yes [ ] No
- b) fibromyalgia [ ] Yes [ ] No
- c) back disorder [ ] Yes [ ] No
- d) joint disorder [ ] Yes [ ] No
- e) musculoskeletal disorder [ ] Yes [ ] No
- f) skin disorder [ ] Yes [ ] No
- g) chronic fatigue syndrome [ ] Yes [ ] No

7. NERVOUS SYSTEM
- a) epilepsy or other seizures [ ] Yes [ ] No
- b) headaches [ ] Yes [ ] No
- c) multiple sclerosis [ ] Yes [ ] No

8. CANCER
- a) cancer [ ] Yes [ ] No
- b) tumor [ ] Yes [ ] No
- c) abnormal growth [ ] Yes [ ] No
- d) carcinoma in situ [ ] Yes [ ] No

9. EAR OR EYE
- a) eye disorder [ ] Yes [ ] No
- b) ear disorder [ ] Yes [ ] No

10. BEHAVIORAL HEALTH
- a) attention deficit disorder [ ] Yes [ ] No
- b) psychological disorder [ ] Yes [ ] No
- c) suicide attempt [ ] Yes [ ] No
- d) eating disorder [ ] Yes [ ] No

11. OTHER
- a) organ or other type of transplant or implant [ ] Yes [ ] No
- b) breast disorder [ ] Yes [ ] No
- c) lupus [ ] Yes [ ] No

F. Within the last 5 years, has anyone named in this application to be covered by this insurance had any other injury, illness or treatment for any condition not already listed; been hospitalized or been scheduled for hospitalization; had surgery or had surgery scheduled; had a test or a test scheduled; or been recommended to have a test or surgery which was not performed for any reason not already mentioned in this application? *We are **not** seeking the results of HIV Antibody test.* [ ] Yes [ ] No

In the space provided below, please list and provide the complete details if you answered "yes" above to questions *A through F.* If you need additional space, please use a separate sheet of paper and attach it to this application (please sign and date the additional sheet).

Question Number	Name of Person	Dates of Treatment	Give full details for each question answered "Yes," state the condition, duration and degree of recovery	Name and address of attending physician or other health care provider

G. If anyone named in this application is taking, has had prescribed or recommended, medication please list all medications, dosages, and what medical condition is being treated with those medications in the space provided below.

Name of Person	**Name, dosage and frequency of medication (*include illness or health condition for which medication was prescribed*)**	**Date(s) medication taken (*indicate if ongoing*)**	**Name and address of prescribing physician or licensed health care provider and dispensing pharmacy**

VII. PROVIDER AND/OR PRODUCT SELECTION, IF APPLICABLE

This section should be completed only if the small employer group health insurance for which you are applying requires the selection of a network, primary care provider, dentist or clinic in order to provide an accurate, fully underwritten premium amount. With respect to the provider/network selection, a selection should be made for each individual applying for such coverage and for each insurer from which insurance coverage is being sought.

The provider numbers may be listed in the provider materials (i.e., directory) that are supplied by each insurer to your employer. The provider numbers for the same provider may not be the same for different insurers or products. Use additional sheets if necessary.

Insurer: _____

Product Type: _____

Coinsurance Option: _____ Deductible Option: _____ Copayment Option: _____

Selected Provider is for (choose only one): [ ] Health Insurance [ ] Dental Insurance [ ] Other _____

Covered Person's Name	Network or Provider's Name and/or Number	Is this your current provider?

Insurer: _____

Product Type: _____

Coinsurance Option: _____ Deductible Option: _____ Copayment Option: _____

Selected Provider is for (choose only one): [ ] Health Insurance [ ] Dental Insurance [ ] Other _____

Covered Person's Name	Network or Provider's Name and/or Number	Is this your current provider?

Insurer: _____

Product Type: _____

Coinsurance Option: _____ Deductible Option: _____ Copayment Option: _____

Selected Provider is for (choose only one): [ ] Health Insurance [ ] Dental Insurance [ ] Other _____

Covered Person's Name	Network or Provider's Name and/or Number	Is this your current provider?

VIII. TERMS AND CONDITIONS

I hereby enroll for coverage under the insurance coverage(s) for which I am presently eligible, or for which I may become eligible under my employer's group contract(s). I have indicated in this Wisconsin Uniform Employee Application for Small Employer Group Health Insurance, if required, the Provider and/or Product Selection. I understand and agree that the information obtained by using this Application will be used by the insurer(s) to determine eligibility for benefits under my employer's group insurance policies. I, on behalf of myself, my spouse and my dependent child(ren), if any, named herein, agree to cooperate in providing the insurer(s) with information needed to process this Application. This might include signing a form for the release by hospitals, doctors, and other health care providers of pertinent heath care records to the Medical Information Bureau, the insurer(s) or their legal representatives.

I acknowledge that I have read and completed the entire Application. If I received assistance in reading or completing this Application, I have identified in the space provided below the person(s) who provided me with such assistance. I declare and agree that the answers are, to the best of my knowledge and belief, complete and true and, together with any supplements or addendums thereto, shall be the basis for any certificate of coverage/certificate of insurance issued. I understand and agree that neither the employer nor the agent has the authority to waive a complete answer to any question, pass on insurability, alter any contract, or waive any of the insurer's other rights or requirements. I additionally agree that the insurer(s) is not liable for any statement, representation, or other information provided to myself or my dependent child(ren) that is not expressly contained in a written document provided to them and signed by an authorized officer of the insurer. I agree that no insurance will be effective until the date specified by the company on the certificate of coverage/certificate of insurance after this application has been accepted. I understand that any misrepresentation contained herein and relied upon by the insurer may be used to reduce or deny a claim or void the contract within the contestable period if such misrepresentation materially affects the acceptance of risk. I also understand that if I decline any coverage, future changes in coverage are NOT automatic and may be subject to the insurer's approval.

I understand and acknowledge that any person who, with intent to defraud or knowledge that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false deceptive statement is committing a fraudulent act that is a crime. I further understand and acknowledge that in some states, any person who, for the purpose of misleading an insurer or other person, conceals significant information from an application or claim is committing a fraudulent act.

If any payroll deductions are required for this coverage, I authorize such deductions from my earnings. I reserve the right to revoke this deduction authorization at any time upon written notice to the employer. An enrollment form should not be submitted more than 30 days prior to the effective date. This document will become a part of the insurance contract when coverage is approved and issued.

I understand that I may request a copy of this Application, the Authorization to Obtain Medical Information, and the Authorization to Obtain Psychotherapy Notes that are part of this Application. I agree that a photographic copy shall be as valid as the original. A legible facsimile signature shall have the same force and effectiveness as the original.

Signature of Employee:_____ **Date Signed:** _____

Signature of Spouse: _____ **Date Signed:** _____

Signature of each listed dependent who has attained the age of 18:

_____ **Date Signed:** _____

_____ **Date Signed:** _____

Complete this section if someone assisted you in the completion of this Application.

The following person assisted me in completing the Application: _____

Please explain your relationship with him/her: _____

AUTHORIZATION TO OBTAIN MEDICAL INFORMATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance or reinsuring company, Medical Information Bureau, Inc., organization, institution or person that has any records or knowledge of me, my spouse, or my minor or dependent children's health and health care, to release any and all such information [including information that constitutes protected health information as defined in the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA Privacy Regulations"), but excluding psychotherapy notes, if any], in any form, including but not limited to, original, electronic, or photographic copies to the following Company(ies) or its reinsurers, or their legal representatives, (hereinafter "the Company"). The information authorized for release shall **not** include whether the individual has obtained a test for the presence of HIV antigen or nonantigenic produces of HIV or an antibody to HIV or what the results of this test were, if obtained by the individual. The Company to whom information may be released includes:

_____

_____

_____

I further authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance or reinsuring company, Medical Information Bureau, Inc., organization, institution that has any health records regarding me, my spouse, or my minor or dependent children, to release any and all such information or records pertaining to drug or alcohol abuse or mental illness diagnosis or treatment to the Company.

Any information obtained will not be released by the Company, or to any person or organization except to reinsuring companies, the plan administrator, plan sponsor, insurance intermediaries, or other persons or organizations performing business or legal services in connection with my application or claims plan renewal, unless as may be otherwise lawfully required or as I may further authorize from time to time.

I understand that I may receive a copy of each insurer's privacy policy and review it prior to signing this Authorization. I also understand that I may revoke this Authorization by providing advance written notice of termination to the Company or any agency employed by the Company. Any information released prior to the receipt of the revocation that were made in reliance upon this Authorization cannot be retrieved nor can persons employed by the Company be held responsible or liable for such release when the release was performed in accordance with the Authorization. I understand that information obtained by this Authorization will be used by the Company to determine eligibility for coverage under my employer's group policy(ies) and that my failure to authorize the release of this information may result in a refusal to issue or provide coverage.

I hereby authorize and request any hospital, clinic, institution, physician, or other licensed health care provider to furnish the insurer selected by my employer, if any, full details of diagnosis, treatment and medical history about me or anyone named in this Application, and to accept as valid a photocopy of this Authorization and my signature. The insurer selected by my employer needs this information to process claims, conduct utilization review and quality improvement activities, and for other health plan activities as permitted by law. The insurer selected by my employer keeps this information confidential, but may release it if you authorize release, or if state or federal law permits or requires release without your authorization. For claims purposes, this release is valid while you are enrolled in the selected health plan and until all claims are adjudicated following your termination of coverage.

I acknowledge that I have received a copy of the Authorization to Obtain Medical Information. I agree this Authorization shall be valid for two and one half years from the date signed and that a copy of this Authorization shall be as valid as the original. I understand that there is a potential for information disclosed pursuant to this Authorization to be subject to redisclosure by the recipient(s) and no longer protected by the HIPAA Privacy Regulations.

To facilitate the rapid submission of such information, I authorize all said sources to give such records or knowledge to any agency employed by the Company, to collect and transmit such information.

_____ _____

Signature of Applicant
(or parent or guardian of proposed insured)

Signature of Applicant's Spouse

_____ _____

Date Signed

Date Signed

AUTHORIZATION PSYCHOTHERAPY NOTES

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance or reinsuring company, Medical Information Bureau, Inc., organization, institution or person that has any records or knowledge of me, my spouse, or my minor or dependent children's psychotherapy notes or information in any form, including but not limited to, original, electronic, or photographic copies, may release this information to the following Company(ies) or its reinsurers, or their legal representatives (hereinafter "the Company"):

_____

_____

_____

Any information obtained will not be released by the Company, to any person or organization except to reinsuring companies, the plan administrator, plan sponsor, insurance intermediaries, or other persons or organizations performing business or legal services in connection with my application or claims plan renewal, unless as may be otherwise lawfully required or as I may further authorize from time to time.

I understand that I may receive a copy of each insurer's privacy policy and review it prior to signing this Authorization. I also understand that I may revoke this Authorization by providing advance written notice of termination to the Company or any agency employed by the Company. Any information released prior to the receipt of the revocation that were made in reliance upon this Authorization cannot be retrieved nor can persons employed by the Company be held responsible or liable for such release when the release was performed in accordance with the Authorization. I understand that information obtained by this Authorization will be used by the Company to determine eligibility for coverage under my employer's group policy(ies) and that my failure to authorize the release of this information may result in a refusal to issue or provide coverage.

I hereby authorize and request any hospital, clinic, institution, physician, or other licensed health care provider to furnish the insurer selected by my employer, if any, full details of diagnosis, treatment and medical history about me or anyone named in this Application, and to accept as valid a photocopy of this Authorization and my signature. The insurer selected by my employer needs this information to process claims, conduct utilization review and quality improvement activities, and for other health plan activities as permitted by law. The insurer selected by my employer keeps this information confidential, but may release it if you authorize release, or if state or federal law permits or requires release without your authorization. For claims purposes, this release is valid while you are enrolled in the selected health plan and until all claims are adjudicated following your termination of coverage.

I acknowledge that I have received a copy of the Authorization to Obtain Psychotherapy Notes. I agree this Authorization shall be valid for two and one half years from the date signed and that a copy of this Authorization shall be as valid as the original. I understand that there is a potential for information disclosed pursuant to this Authorization to be subject to redisclosure by the recipient(s) and no longer protected by the HIPAA Privacy Regulations.

To facilitate the rapid submission of such information, I authorize all said sources to give such records or knowledge to any agency employed by the Company, to collect and transmit such information.

_____ _____

Signature of Applicant
(or parent or guardian of proposed insured)

Signature of Applicant's Spouse

_____ _____

Date Signed

Date Signed

_____

Signature of Minor or Dependent Child,
(if treatment was received without parental consent, in accordance with state law)

_____

Date Signed

STATE OF WISCONSIN **OFFICE OF THE COMMISSIONER OF INSURANCE (OCI)**

★★★ NOTICE OF RULEMAKING HEARING ★★★

NOTICE IS HEREBY GIVEN that pursuant to the authority granted under s. 601.41(3), Stats., and the procedure set forth in under s. 227.18, Stats., OCI will hold a public hearing to consider the adoption of the attached proposed rulemaking order affecting Section Ins 8.49, Wis. Adm. Code, relating to Small Employer Uniform Employee Application.

HEARING INFORMATION

Date: **July 11, 2003**
Time: **9:30 a.m., or as soon thereafter as the matter may be reached**
Place: **Room 227, OCI, 125 South Webster Street, Madison, WI**

Written comments on the proposed rule will be accepted into the record and receive the same consideration as testimony presented at the hearing if they are received at OCI within 14 days following the date of the hearing. Written comments should be addressed to: Julie E. Walsh, OCI, PO Box 7873, Madison WI 53707

SUMMARY OF PROPOSED RULE & FISCAL ESTIMATE

For a summary of the rule see the analysis contained in the attached proposed rulemaking order. There will be no state or local government fiscal effect. The full text of the proposed changes and the fiscal estimate are attached to this Notice of Hearing.

INITIAL REGULATORY FLEXIBILITY ANALYSIS

Notice is hereby further given that pursuant to s. 227.114, Stats., the proposed rule may have an impact on small businesses. The intended effect of the rule will be to reduce use of employee time for completion of application materials that should result in a cost savings to the small employers. There should be no fiscal increase incurred by small employers.

CONTACT PERSON

A copy of the full text of the proposed rule changes and fiscal estimate may be obtained from the OCI internet WEB site at **http://www.state.wi.us/agencies/oci/ocirules.htm** or by contacting Inger Williams, Services Section, Office of the Commissioner of Insurance, at (608) 264-8110 or at 121 East Wilson Street, PO Box 7873, Madison WI 53707-7873.