45 Nob Hill Rd. • P.O. Box 7338 • Madison, WI 53707-7338 • T 800.279.4000 F 608.276.9119 • WeaTrust.com

Enrollment Checklist

Avoid these common mistakes to avoid delays in coverage processing.

- ☐ Please print legibly
- ☐ Make sure you complete the enrollment even if you are waiving coverage
- ☐ If covering spouse and/or dependents, make sure you know their Social Security Numbers and dates of birth
- ☐ Check with your employer for:
  - The WEA Trust Group Number
  - Which plans [Health, Vision, Dental, Long Term Disability, Long Term Care, Life, and/or Short Term Disability] you and your dependents are eligible for
  - Your exact annual salary
  - Your First Day of Employment [first day actively at work not necessarily the day you sign a contract]
  - The occupation to use ….

Public Schools		Public Sector
ADM.SEC'Y/ASSISTANT	EMPLOYER DEFINED/OTHER	ADMINISTRATION
ADMIN./PRINCIPAL	FOOD SERV.SUPERVISOR	CORRECTIONAL WORK
AIDE-TEACHER/LIBRARY	LIBRARIAN	EMPLOYER DEFINED/OTHER
AUDIO/VISUAL TECH.	LONG TERM SUBS	FINANCE
BLDING/GROUNDS SUPV.	MECHANIC	FIRE PROTECTION
BOOKKEEPER/PAYROLL	NURSE/THERAPIST	HR/SOC/PUBL HLTH
BUS DRIVER	PSYCHOLOGIST/IATRIST	LEGAL COUNSEL
BUSINESS MANAGER	SECRETARY/CLERICAL	POLICE PROTECTION
COMPUTER TECH	SUBSTITUTE TEACHER	UTILITY/SANITATION
COOK/FOOD SERVICE	TEACHER	
COUNSELOR	TRANSPORTATION DIRECTOR	
CUSTODIAL/MAINTENANCE		

- ☐ If eligible for the **Long Term Care** plan and you wish to cover your spouse/domestic partner, remember to submit the *Evidence of Insurability for Group Long Term Care*
- ☐ If eligible for a **Life** plan, the *Life Insurance Beneficiary Designation* should be completed, signed, and dated. If your spouse/domestic partner is not designated as Primary Beneficiary, his/her signature is required
- ☐ If eligible for a **Short Term Disability** plan, remember that:
  - A separate enrollment form is required
    - Weekly benefit amounts of $357 and larger require underwriting approval
    - Remember to submit and complete the *Evidence of Insurability For Short Term Disability Plan* form

Enrollment Form

WEA Insurance Corporation
P.O. Box 7338, Madison, WI 53707 • (800) 279-4000
WeaTrust.com

Applications not completed in full will not be processed.

SECTION 1 – Employee Information

Employee Name (Last, First, Middle Initial)

Gender
☐ Male ☐ Female

Marital Status
☐ Single ☐ Married ☐ Divorced ☐ Widowed

Street Address (or P. O. Box) **City** **State** **Zip**

Date of Birth (MM/DD/YYYY) **Telephone Number**

Social Security Number **Subscriber Number** (not applicable for first time enrollment)

Are you:
☐ totally disabled? ☐ on sick leave? ☐ on medical leave? ☐ retired? ☐ on COBRA? If YES, please provide start date: / /

SECTION 2 – Employment Information

Employer Name

WEA Trust Group Number **First Day of Employment** (MM/DD/YYYY) **Annual Salary** **Average Hours Worked/Week**

Occupation

SECTION 3 – Reason for Application

Choose one event:

☐ New employee
☐ Rehire
☐ Return from layoff
☐ Return from leave
☐ Loss of other group coverage
☐ Group annual enrollment
☐ Late applicant
☐ Birth, Adoption/placement for adoption
☐ Marriage, adding spouse and/or dependents
☐ Change in work hours. Indicate the number of hours per week you *were* working: _____ hours
☐ Divorce
☐ Change of Occupation
☐ Change of beneficiary information (please complete Beneficiary Section on page 4)
☐ Other: _____

Date that the event indicated above occurred (MM/DD/YYYY)

(Continue to next page)

Subscriber Number or Employee Social Security Number: _____

SECTION 4 – Type of Insurance Coverage *(to determine which plans you are eligible for, check with your employer)*

Indicate insurance for which you are applying:

- ☐ Health _____
- ☐ Vision
- ☐ Dental
- ☐ Long Term Disability (LTD)
- ☐ Long Term Care (LTC)
- ☐ Life

If applying for Life insurance:

- ☐ Additional Purchase

Please indicate the amount:

- ☐ $25,000 ☐ $75,000
- ☐ $50,000 ☐ $100,000
- ☐ $ _____

Life Insurance options (select one)

- ☐ Dependent Life Insurance ($7,500 spouse & $3,750 children)
- ☐ Double Dependent Life Insurance ($15,000 spouse & $7,500 children)

SECTION 5 – 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:

☐ Myself ☐ My spouse/domestic partner ☐ My dependent child(ren) ☐ Me, my spouse/domestic partner and my dependent child(ren)

Reasons for the waiver:

☐ Persons listed above have other insurance ☐ Good health ☐ My earnings are such that I would have to pay more than 10% of my annualized gross earnings towards health insurance.

I also am waiving coverage for these other coverages (check appropriate box(es):

☐ Vision ☐ Dental ☐ Long Term Disability (LTD) ☐ Long Term Care (LTC) ☐ Life

SECTION 6 – Health/Dental Insurance and Medicare Information

Is your spouse/domestic partner or are any of your dependent children disabled? ☐ NO ☐ YES

If YES, please state the dependent's name(s), nature of the disability, and the Medicare number if applicable:

Will you or any family member(s) continue or maintain any other health or dental insurance or self-funded group medical plan in addition to the insurance being applied for today? ☐ NO ☐ YES

If YES, please complete the following:

Family Member Name	Insurance Company / Plan	Group Number	Type of Coverage	Type of Plan	Effective Date of Coverage	Cancellation Date
1.			☐ Family ☐ Single	☐ Medical ☐ Dental		
2.			☐ Family ☐ Single	☐ Medical ☐ Dental		
3.			☐ Family ☐ Single	☐ Medical ☐ Dental		

Are you or any of your family members eligible for Medicare? ☐ NO ☐ YES

If YES, please complete the following or attach a copy of your Medicare card:

Name of person covered by Medicare **Medicare Number**

Is Medicare eligibility due to: ☐ Age ☐ End-Stage Renal Disease (ESRD) ☐ Total disability

Effective Dates: Part A Part B Part C (Medicare Advantage) Part D

Does a divorce decree affect insurance coverage for any dependent children covered by your Trust policy? ☐ NO ☐ YES

If YES, please send a copy of the portion of the divorce decree that stipulates health/dental coverage.

(Continue to next page)

Subscriber Number or Employee Social Security Number: ______________________________

SECTION 7 – Dependent Information *(Please complete in full)*

SPOUSE / DOMESTIC PARTNER Name (Last, First, Middle Initial) | **Date of Birth** (MM/DD/YYYY) | **Social Security Number**

Gender
☐ Male ☐ Female

Type of Insurance Plan
☐ Health ☐ Vision ☐ Dental ☐ LTC ☐ Life

Dependent Name (Last, First, Middle Initial) | **Date of Birth** (MM/DD/YYYY) | **Social Security Number**

Gender
☐ Male ☐ Female

Type of Insurance Plan
☐ Health ☐ Vision ☐ Dental ☐ Life

Relationship
☐ Child ☐ Stepchild ☐ Grandchild ☐ Other:

Dependent Name (Last, First, Middle Initial) | **Date of Birth** (MM/DD/YYYY) | **Social Security Number**

Gender
☐ Male ☐ Female

Type of Insurance Plan
☐ Health ☐ Vision ☐ Dental ☐ Life

Relationship
☐ Child ☐ Stepchild ☐ Grandchild ☐ Other:

Dependent Name (Last, First, Middle Initial) | **Date of Birth** (MM/DD/YYYY) | **Social Security Number**

Gender
☐ Male ☐ Female

Type of Insurance Plan
☐ Health ☐ Vision ☐ Dental ☐ Life

Relationship
☐ Child ☐ Stepchild ☐ Grandchild ☐ Other:

Dependent Name (Last, First, Middle Initial) | **Date of Birth** (MM/DD/YYYY) | **Social Security Number**

Gender
☐ Male ☐ Female

Type of Insurance Plan
☐ Health ☐ Vision ☐ Dental ☐ Life

Relationship
☐ Child ☐ Stepchild ☐ Grandchild ☐ Other:

Dependent Name (Last, First, Middle Initial) | **Date of Birth** (MM/DD/YYYY) | **Social Security Number**

Gender
☐ Male ☐ Female

Type of Insurance Plan
☐ Health ☐ Vision ☐ Dental ☐ Life

Relationship
☐ Child ☐ Stepchild ☐ Grandchild ☐ Other:

SECTION 8 – Signature and Authorization

I understand that if I do not apply for health coverage when initially eligible and instead apply later, my dependents and I may have to exhaust a 12-month waiting period before coverage is effective. I understand that if I do not apply for other types of coverage when initially eligible and instead apply later, my dependents and I will be required to meet very strict standards of insurability and there is no guarantee I/we will be accepted for coverage. I understand that the amount of life coverage applied for may require me or my dependents to meet standards of insurability before such coverage is effective. If any of the plans require a salary deduction, I hereby authorize my employer to make all necessary deductions.

Signature | **Date** (MM/DD/YYYY)

(If applying for Life Insurance, please continue to next page)

Enrollment Form Life Insurance Beneficiary Designation

Insured Employee Information

Employee Name (Last, First, Middle Initial)

Social Security Number | **Subscriber Number** (not applicable for first time enrollment)

Reason for Completing Form (select one)

☐ Initial Designation of Beneficiary ☐ Change of Designation of Beneficiary

Beneficiary Information

Please list your beneficiary's name and relationship to you in the spaces provided. If you list a beneficiary that is not a person (e.g., a charitable organization or trust), please list the relationship as "other." If you designate more than one beneficiary, we will pay the benefits equally to each of your designated beneficiaries. If you want us to pay the benefits in differing percentages, please indicate the percentage for each beneficiary in the space provided. The total for all beneficiaries must equal 100%. If you do not have a named beneficiary, or no beneficiary survives you, payment will be made according to policy provisions.

The beneficiary for insurance on the lives of your dependents will automatically be you, if surviving. Otherwise, the beneficiary will be subject to policy provisions. A beneficiary for employee life or accidental death insurance may be changed upon written request.

Beneficiary Type (select one)	Name (Last, First, Middle Initial)		Relationship to You
☐ Primary ☐ Contingent	Date of Birth (MM/DD/YYYY)	Social Security Number	Percentage of Proceeds %
Beneficiary Type (select one)	Name (Last, First, Middle Initial)		Relationship to You
☐ Primary ☐ Contingent	Date of Birth (MM/DD/YYYY)	Social Security Number	Percentage of Proceeds %
Beneficiary Type (select one)	Name (Last, First, Middle Initial)		Relationship to You
☐ Primary ☐ Contingent	Date of Birth (MM/DD/YYYY)	Social Security Number	Percentage of Proceeds %
Beneficiary Type (select one)	Name (Last, First, Middle Initial)		Relationship to You
☐ Primary ☐ Contingent	Date of Birth (MM/DD/YYYY)	Social Security Number	Percentage of Proceeds %

Spousal Consent *(complete only if spouse is not designated as primary Beneficiary)*

As spouse of the employee named above, I hereby consent to my spouse designating the person(s) listed above as beneficiaries of group life or accidental death insurance under the above policy and waive any rights I may have to the proceeds of such insurance under applicable community property laws. I understand that this consent and waiver supersede any prior spousal consent or waiver under this plan.

Signature of Employee's Spouse | **Date** (MM/DD/YYYY)

Signature and Authorization

IMPORTANT: This beneficiary designation revokes all prior beneficiary designations. If you are changing your beneficiary, we will confirm the change in writing. Beneficiary designations are not valid without a signature and date.

Signature | **Date** (MM/DD/YYYY)

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