REQUIRED

NEW HIRE - EIT/RESIDENT

Health Insurance Application/Change

Residents/Intern are NOT eligible to enroll in the HDHP/HSA

UWHC OFFICE USE ONLY

Empl ID:
Pay Group: EIT
Reason for App: New Hire

There are certain times throughout the year when you may enroll in health insurance or change your coverage. Visit etf.wi.gov/benefits-by-employer to learn more about choices available to you, view an eLearning and see instructions on how to enroll. **Return this completed form to your employer.** Return: Upload to MedHub

Your health insurance deductions will be taken pre-tax unless you request they be taken post-tax. Contact your employer to make this change or submit the *Employee Reimbursement Accounts Program Automatic Premium Conversion Waiver/Revocation of Waiver* (ET-2340) to your employer.

1. Applicant Information *Only the subscriber applying for coverage/making a change should complete this form.* REQUIRED

Check here if your name, phone, address, email or marital status has changed: ☐ *List updated information below*

Name *First*	*M.I.*	*Last*	ETF ID Leave Blank	SSN

Former/Maiden (if applicable)	Telephone ( )	Email

Mailing address (Street) City State ZIP code Country

Birth date	Gender ☐ Male ☐ Female	Primary care physician or clinic SPECIFIC Physician name or clinic location for this plan - in most cases will NOT be your current PCP

Check your marital status: If selecting married, divorced or widowed, must enter date

☐ Single *(no change date required)* ☐ Married Date: _____ ☐ Divorced Date: _____ ☐ Widowed Date: _____

Please check which applies to you (this determines your eligibility)

☐ Employee ☐ Graduate assistant ☐ COBRA recipient ☐ Surviving dependent

2. Spouse Information (if adding or covered on your plan) REQUIRED if married, spouse information must be included on application, regardless of being covered by health insurance

Name *First*	*M.I.*	*Last*	*Former/Maiden*	SSN

Birth date	Gender ☐ Male ☐ Female	Primary care physician or clinic SPECIFIC Physician name or clinic location

Check here if your spouse's information has changed: ☐

3. Dependent Information (if adding or covered on your plan; this does not include spouse) Dependent Information only required if enrolling onto your plan

Name *You may attach additional pages if more space is needed*			SSN	Birth date	Gender (M/F)	Relationship (child, stepchild, legal ward, dependent of minor dependent)	Disabled (Y/N)	Check if removing	Primary care physician or clinic
First	*M.I.*	*Last*							

Is any dependent listed here your or your spouse's grandchild? ☐ Yes ☐ No

If yes, name of parent: _____

Name: _____ ETF ID: _____

4. Are you eligible to enroll or make a change?

You can modify your benefits during the annual IYC open enrollment, your initial hire period and in response to an eligible life event change. Eligible life changes are listed below.

Reason for Application: Select a reason for enrolling or changing your coverage or health plan:

- ☐ ~~Health benefits open enrollment~~
- ☐ New hire (when do you want coverage to be effective, see below)
- ☐ ~~Eligible life event change (select change below) - Life event change date: _____~~
- ☐ ~~Eligible move to a new service area *(may only change health plan)* - Move date: _____~~

New hires or employees returning from leave (lapsed coverage) *only*: Choose your coverage to be effective:

- ☐ When my employer contributes to my premium
- ☐ ~~As soon as possible (you will pay the entire monthly premium until you are eligible for your employer contribution)~~
- ☐ ~~I choose to decline/waive coverage *(to decline health insurance and elect the opt-out incentive, go to section 12)*~~
- ☐ I choose to decline/waive coverage *because I have other health insurance coverage (go to section 13 and sign)*

~~Eligible life event changes, which allow you to make a change outside of the annual health benefits open enrollment (or your initial hire period), include birth/adoption, marriage and divorce. Visit etf.wi.gov for a *Life Change Event Guide*.~~

~~Select one reason to add coverage/dependent or remove dependent(s):~~

~~Add coverage/dependent(s)~~ *~~(complete section 3)~~*

- ☐ ~~Marriage*~~
- ☐ ~~Transfer to a new state agency (state only)~~
  ~~Former agency name: _____~~
- ☐ ~~Birth or adoption*~~
- ☐ ~~LTE new hire (state only)~~
- ☐ ~~COBRA (*Continuation Conversion Notice* (ET-2311) required)~~
- ☐ ~~National Medical Support Notice*~~
- ☐ ~~Spouse-to-spouse transfer~~
- ☐ ~~Loss of employer contributions or loss of other coverage*~~
- ☐ ~~State retiree re-enroll*~~
- ☐ ~~Paternity acknowledgment*~~
- ☐ ~~Legal ward/guardianship*~~
- ☐ ~~Disabled, age 26+*~~
- ☐ ~~Dependent not on initial enrollment (excludes adult dependents)~~
- ☐ ~~Other: _____~~

~~Remove dependent(s)~~ *~~(complete section 8)~~*

- ☐ ~~Divorce*~~
- ☐ ~~Death of dependent~~
- ☐ ~~Legal ward/guardianship end*~~
- ☐ ~~Disabled dependent disability end or support/maintenance less than 50%~~
- ☐ ~~Grandchild's parent age 18~~
- ☐ ~~Adult dependent eligible for other coverage*~~
- ☐ ~~Other: _____~~

~~**You may be required to provide supporting documentation*~~

5. Choose an It's Your Choice (IYC) Plan Design

Compare factors like monthly payments, coverage levels and out-of-network benefits availability. See your health benefits materials or your employer for specific options available to you, and descriptions of each plan design. If you are not changing the options below, you do not need to complete this section. **REQUIRED**

Select one: ☐ IYC health plan *(You must select a health plan in section 6.)*
☐ Access Plan *(Your health plan will be WEA Trust. Skip section 6.)*

Make your plan design (chosen above) a High Deductible Health Plan (HDHP)? ☐ Yes ☒ No **Residents/Interns are NOT eligible for HDHP**

Individual or family coverage? ☐ Individual ☐ Family

With or without dental? ☐ With dental ☐ Without dental *(Your dental plan will be Delta Dental.)* This is Uniform Delta Dental

State employees: If you elect HDHP, you must also enroll in the state-sponsored health savings account (HSA). You are not eligible for an HDHP if you have other coverage. You may enroll in an HDHP if your dependents have other coverage.

Local Wisconsin Public Employer (WPE) employees: You can only enroll in the plan designs your employer offers, including dental. Check with your employer.

6. Choose a Health Plan

All health plans provide the same in-network benefits. Choose a plan based on where you live or work, see health plan performance ratings and consider monthly premiums. Health plan provider directories are available online. REQUIRED - Full health plan name must be included if enrolling in health insurance

Enter the complete health plan name here. See your health benefits materials for your options. Ex. Quartz UW, Quartz Community, Dean, GHC, etc. If enrolling in Access Plan, health plan name = Access Plan

Name: _____ ETF ID: _____

7. Complete if you or any of your Dependents are Covered by Medicare

Complete for all persons covered by Medicare, including yourself. Eligibility reasons include age, disability or end-stage renal disease (ESRD).

Name (*first, m.i., last*)	Medicare number	Part A effective date	Part B effective date	Why eligible?
				☐ Age ☐ Disability ☐ ESRD
				☐ Age ☐ Disability ☐ ESRD
				☐ Age ☐ Disability ☐ ESRD
				☐ Age ☐ Disability ☐ ESRD

8. Remove a Spouse or Dependent(s)

Name of person(s) you are removing *(first, m.i., last)*	Birth date	Address (if different than your address on page 1)

9. Complete if you are Changing from Family to Individual Coverage

If your employee monthly premium share is pre-tax, IRC Section 125 restricts midyear changes to your coverage. For more information on IRC Section 125 limitations, visit www.irs.gov.

My employee-required monthly premium contribution is deducted (*check one*):

- ☐ Pre-tax and my employee premium contribution has increased significantly
- ☐ Pre-tax eligible life event change – what was the event? _____
- ☐ Pre-tax change to individual during annual It's Your Choice (January 1)
- ☐ Post-tax (midyear changes to coverage level can be made at any time) – Event date: _____

10. Cancel Health Insurance Coverage

Only complete this section to cancel coverage entirely. Do not complete if you are changing health coverage.

My premiums are deducted:
- ☐ Pre-tax (select a life change event below)
- ☐ Post-tax (no event required to cancel coverage)

Choose one reason for canceling coverage:
- ☐ It's Your Choice open enrollment; cancel all coverage for next year
- ☐ I am terminating employment
- ☐ My employee premium share has increased significantly
- ☐ I and all eligible dependents are now eligible for, and enrolled in, other coverage – Event date: _____ *(you must provide proof)*
- ☐ Spouse-to-spouse transfer – Event date: _____
- ☐ I am going on an unpaid leave of absence *(you may want to let your coverage lapse instead; see your employer)*

11. Do you Have Other Health Insurance Coverage

REQUIRED ONLY enter if your other coverage will be ongoing and overlaps with this new coverage

Do you or any of your dependents have other medical coverage or health care flexible spending account coverage that has a balance available as of the effective date of this coverage (excludes dental or vision)?
- ☐ No
- ☐ Yes (complete other health insurance information)

Name of health insurance company:_____

Policy number: _____ Group number: _____

Name(s) of insured: _____

Name: _____ ETF ID: _____

12. ~~*State Employees Only*: Decline Health Insurance & Elect the Opt-Out Incentive~~

~~Are you electing to receive the opt-out incentive for 2020?~~ ☐ ~~Yes~~ ☐ ~~No~~ EIT/Resident/Intern not eligible for Opt Out

~~*If yes, you certify you are eligible for the opt-out stipend and are not currently, nor will be this program year, a covered dependent under the State of Wisconsin Group Health Insurance Program, and that you did not decline or waive coverage in 2015.*~~

13. Signature *Required*

REQUIRED

By signing this application, I apply for the insurance under the indicated health insurance contract made available to me through the State of Wisconsin and I have read and agreed to the *Terms and Conditions* (see page 5). A copy of this application is considered as valid as the original. In addition, to the best of my knowledge, all statements and answers in this application are complete and true. Providing false information is punishable under Wis. Stat. § 943.395. Additional documentation may be required by ETF at any time to verify eligibility.

Signature	Date

Return this completed form to your employer.

If Returning via MedHub, an e-signature is allowed.

If returning via any other method, A REAL, HANDWRITTEN SIGNATURE IS REQUIRED - NO E-SIGNATURES

UWHC Notes:
Please ensure application is filled out thoroughly and completely. Submitting incomplete information delays our ability to process your application, and may result in a delay in enrollment.
If enrolling in family coverage, State statute requires that all family members be listed (including spouse and all dependents under the age of 19) - you cannot choose to leave someone off the family plan unless you provide proof of other coverage.

If you have questions about your benefits, or your enrollment application, please contact:
UW Health HR Service Center
Submit an Ask HR case
phone: 608-263-6500
fax: 608-263-5778

If enrolling:

- Section 1 - must list a specific PCP name or clinic location
- Section 2 - if you have a spouse, complete; even if you are enrolling in single coverage
- Section 3 - answer every question for each dependent listed
- Section 5 - Answer each of the questions
- Section 6 - Must write in which plan you are choosing
- Section 7 - Complete if you/dependents are covered by medicare
- Section 11 - check yes/no; if yes, complete additional information

If Waiving:

- Section 1 - Personal info must be completed (do not need to list PCP)
- Section 4 - I choose to decline/Waive
- Section 13 - signature/date

Employer Completes Coding instructions are in the *Employer Health Insurance Administration Manual*.

EIN	Employer name		Payroll representative email	
0001-183	UWHC Authority		hr@uwhealth.org	
Group number	Employee type	Coverage type	Health plan name/suffix	
83532	12	☐ Individual ☐ Family		
Business Unit *(if applicable)*	Employment status of applicant		Employee deductions	
N/A	☐ Full time ☐ Part time ☐ LTE		☐ Pre-tax ☐ Post-tax	
Hire date or date WRS-eligible employment or graduate appointment began	Employer received date		Event date	Prospective coverage date

Are you a WRS-participating employer? ☒ Yes ☐ No
Previous service check completed? ☐ Yes ☐ No
Source of previous service check? ☐ Online Network for Employers (ONE) ☐ ETF
Did employee participate in the WRS prior to being hired by you? ☐ Yes ☐ No

Payroll representative signature	Phone number	Date signed
	(608) 263-6500	

Terms and Conditions

To the best of my knowledge, all statements and answers in this application are complete and true. I understand that if I provide false or fraudulent information, misrepresentation or fail to provide complete or timely information on this application, I may face action, including, but not limited to, loss of coverage, employment action, and/or criminal charges/sanctions under Wis. Stat. § 943.395.

I authorize the Department of Employee Trust Funds to obtain any information from any source necessary to administer this insurance.

I agree to pay in advance the current premium for this insurance, and I authorize my employer (the remitting agent) to deduct from my wages or salary an amount sufficient to provide for regular premium payments that are not otherwise contributed. The remitting agent shall send the premium on my behalf to ETF.

I understand that eligibility for benefits may be conditioned upon my willingness to provide written authorization permitting my health plan and/or ETF to obtain medical records from health care providers who have treated me or any dependent(s). If medical records are needed, my health plan and/or ETF will provide me with an authorization form. I agree to respond to questions from health plans and ETF, including, but not limited to, audits, in a timely manner.

I have reviewed and understand the eligibility criteria for dependents under this coverage and affirm that all listed dependents are eligible. I understand that children may be covered through the end of the month they turn 26. Children may also be covered beyond age 26 if they: have a disability of long standing duration, are dependent on me or the other parent for at least 50% of support and maintenance, and are incapable of self-support; or are full-time students and were called to federal active duty when they were under the age of 27 years and while they were attending, on a full-time basis, an institution of higher education.

I understand that it is my responsibility to notify the employer, or if I am a retiree or continuant to notify ETF, if there is a change affecting my coverage, including but not limited to, a change in eligibility due to divorce, marriage or an address change due to a residential move. Furthermore, failure to provide timely notice may result in loss of coverage, delay in payment of claims, loss of continuation rights and/or liability for claims paid in error. Upon request, I agree to provide any documentation that ETF deems necessary to substantiate my eligibility or that of my dependent(s).

I understand that if there is a qualifying event in which a qualified beneficiary (me or any dependent(s)) ceases to be covered under this program, the beneficiary(ies) may elect to continue group coverage as permitted by state or federal law for a maximum of 18, 29, or 36 months, depending on the type of qualifying event, from the date of the qualifying event or the date of the notice from my employer, whichever is later. I also understand that if continuation coverage is elected by the affected qualified beneficiary(ies) and there is a second qualifying event (i.e, loss of eligibility for coverage due to death, divorce, marriage but not including non-payment of premium) or a change in disability status as determined by the Social Security Administration, continuation coverage, if elected subsequent to the second qualifying event, will not extend beyond the maximum of the initial months of continuation coverage. I understand that timely notification of these qualifying events must be made to ETF.

I understand that if I am declining enrollment for myself or my dependent(s) (including spouse) because of other health insurance coverage, I may be able to enroll myself and my dependent(s) in this plan if I or my dependent(s) lose eligibility for that other coverage (or if the employer stops contributing toward that other coverage). However, I must request enrollment within 30 days after my or my dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if I have (a) new dependent(s) as a result of marriage, birth, acknowledgement of paternity, adoption, or placement for adoption, I may be able to enroll myself and my dependent(s) if I request enrollment within 30 days after the marriage or within 60 days after the birth, acknowledgement of paternity, adoption, or placement for adoption. To request special enrollment or obtain more information, I should contact my employer (or ETF if I am a retiree or continuant).

I understand that I am responsible for enrolling in Medicare Parts A and B when I am first eligible and required by this coverage, and that as the subscriber I am responsible for ensuring my spouse and any other eligible dependents also enroll in Medicare Parts A and B when they are first eligible, to ensure proper coordination of benefits with Medicare. In the event I or any eligible dependent does not enroll in Medicare Parts A and B when first eligible and required by this group health insurance program, I understand that I will be financially liable for the portion of claims Medicare would have paid had proper Medicare enrollment been attained.

I understand that if I enrolled in Medicare Advantage with an individual or family contract and subsequently I or my dependents cancel Medicare coverage, I and all covered dependents on the contract will be unenrolled from the Medicare Advantage plan and enrolled in the IYC Medicare Plus plan effective the date of loss of Medicare coverage. I understand that I will be financially liable for the portion of claims Medicare would have paid had proper Medicare enrollment been attained.

I agree to abide by the terms of my benefit plan, as explained in any written materials I receive from ETF or my health plan, including, without limitation, the It's Your Choice materials.

Documentation Requirements

Reason for Change or Enrollment	Type of Documentation
*Adoption	Recorded copy of court order granting adoption or letter of placement for adoption.
*Cancel coverage/remove adult dependent due to enrollment in other health insurance coverage when premium contributions are deducted pre-tax	Copy of medical ID card or letter from health plan indicating effective date of other coverage. Must be received within 30 days of enrollment in other coverage. Does not apply to retirees or post-tax deductions.
*Death	Original death certificate.
*Disabled, age 26+	Copy of letter from health plan approving disabled status.
*Divorce (Family coverage remains in place when more dependents than spouse/stepchildren covered.)	Copy of *Continuation-Conversion Notice* (ET-2311) sent to ex-spouse of the subscriber. (ETF may request copy of divorce decree from clerk of courts showing date of entry of divorce if needed per the Terms and Conditions.)
*Eligible **and** enrolled in Medicare	Copy of Medicare card and *Medicare Eligibility Statement* (ET-4307). (**Note**: If you are on COBRA Continuation and the subscriber or dependents become Medicare eligible after the COBRA effective date, subscriber or dependent is no longer eligible to continue on COBRA.)
*Family to individual because all dependents enrolled in other coverage	Copy of medical ID card or letter from health plan indicating effective date of other coverage. Must be received within 30 days of enrollment in other coverage. Does not apply to retirees or post-tax deductions.
*Legal change of name (other than due to marriage or divorce)	Copy of court order.
*Legal ward	Court Order (Letters of Guardianship) granting **permanent** guardianship of person.
*Loss of other coverage or loss of employer contribution to premiums (applies to participant and dependents)	The following items on letterhead from the previous insurer or former employer, dated and issued after termination of coverage. Materials providing prospective termination dates are not acceptable. 1. Who was covered (must list the name of the participant who is requesting this special, late enrollment) 2. Name of Health Insurer 3. Subscriber name 4. Date coverage was terminated 5. Reason for the cancellation (that is voluntary such as due to non-payment of premium vs. involuntary such as due to job loss). COBRA notice is acceptable if the coverage end date, covered individuals and health plan are indicated. If loss of employer premium contributions, letter from employer indicating they no longer contribute toward their employee's premium.
*National Medical Support Notice	Copy of National Medical Support Notice.
*Paternity	Court order declaring paternity, Voluntary Paternity Acknowledgement filed with DHS or birth certificate.
*Social Security number change	Copy of card or letter from Social Security Administration.
*State retiree re-enroll	Same as loss of other coverage and a *Sick Leave Re-enrollment Application* (ET-4317). During It's Your Choice, no documentation required.
Birth	Birth certificate required for single parent. (ETF may request documentation for married couples per the Terms and Conditions.)
Change of address/telephone	No documents required but ETF may request per the Terms and Conditions.
Divorce (family to individual)	No documents required but ETF may request per the Terms and Conditions.
Marriage	ETF may request original or certified copy of marriage certificate per the Terms and Conditions.

*Documentation required/must be submitted to ETF.

Discrimination is Against the Law 45 C.F.R. § 92.8(b)(1) and (d)(1)
The Wisconsin Department of Employee Trust Funds complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. ETF does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

ETF provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats. ETF provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact ETF's Office of Policy, Privacy & Compliance, which serves as ETF's Civil Rights Coordinator.

If you believe that ETF has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Compliance Officer, Department of Employee Trust Funds, P.O. Box 7931, Madison, WI 53707-7931; 1-877-533-5020; TTY: 711; Fax: 608-267-4549; Email: ETFSMBPrivacyOfficer@etf.wi.gov. If you need help filing a grievance, ETF's Compliance Office is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201; 1-800-368-1019; TDD: 1-800-537-7697. Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-533-5020 (TTY: 711).

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-877-533-5020 (TTY: 711).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-533-5020（TTY：711）

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-533-5020 (TTY: 711).

Arabic: ملاحظة: إذا كنت تتحدث اللغة العربية، فهناك خدمة مساعدة متاحة بلغتك دون أي مصاريف: اتصل بالرقم 1-877-533-5020 (خدمة الصم والبكم: 711)

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-533-5020 (телетайп: 711).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-533-5020 (TTY: 711)번으로 전화해 주십시오.

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-533-5020 (TTY: 711).

Pennsylvania Dutch: Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-877-533-5020 (TTY: 711).

Laotian/Lao: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-877-533-5020 (TTY: 711).

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-533-5020 (ATS : 711).

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwońpod numer 1-877-533-5020 (TTY: 711).

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-877-533-5020 (TTY: 711) पर कॉल करें।

Albanian: KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, papagesë. Telefononi në 1-877-533-5020 (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-533-5020 (TTY: 711)

Health Plan Contact Information

Dean Health Insurance
1277 Deming Way
Madison, WI 53717
Telephone: 1-800-279-1301
Fax: 608-827-4212
Dean On Call: 1-800-576-8773
Website: deancare.com/wi-employees

Dean Health Insurance-Prevea360 Health Plan
2710 Executive Drive
Green Bay, WI 54304
Telephone: 1-877-230-7555
Prevea Care After Hours: 1-888-277-3832
Website: prevea360.com/wi-employees

Group Health Cooperative
of Eau Claire (GHC-EC)
P.O. Box 3217
Eau Claire, WI 54702
Telephone: 1-888-203-7770, 715-552-4300
Fax: 715-552-3500
Website: group-health.com

Group Health Cooperative of South Central Wisconsin
(GHC-SCW)
1265 John Q. Hammons Drive
P.O. Box 44971
Madison, WI 53717-4971
Telephone: 1-800-605-4327, 608-828-4853
Fax: 608-662-4186
Website: ghcscw.com

HealthPartners Health Plan
P.O. Box 1309
Minneapolis, MN 55440-1309
Telephone: 1-855-542-6922, 952-883-5000
Fax: 952-883-5666
Website: healthpartners.com/stateofwis

Medical Associates Health Plans
1605 Associates Drive, Suite 101
Dubuque, IA 52002
Telephone: 1-866-421-3992
Fax: 563-584-4760
Website: mahealthplans.com

MercyCare Health Plans
580 N. Washington Street
P.O. Box 550
Janesville, WI 53547-0550
Telephone: 1-800-895-2421 option 5
Fax: 608-752-3751
Website: mercycarehealthplans.com

Navitus Health Solutions
P.O. Box 999
Appleton, WI 54912-0999
Telephone: 1-866-333-2757
Website: www.navitus.com

Navitus MedicareRx (PDP)
(Prescription drug coverage for
Medicare eligible retirees)
P.O. Box 1039
Appleton, WI 54912-1039
Telephone: 1-866-270-3877
Website: medicarerx.navitus.com

Network Health
1570 Midway Place
P.O. Box 120
Menasha, WI 54952
Telephone: 1-844-625-2208, 920-720-1811
Fax: 920-720-1909
Website: networkhealth.com/employer/state

Quartz
840 Carolina Street
Sauk City, WI 53583-1374
Telephone: 1-844-644-3455
Fax: 608-643-2564
Website: ChooseQuartz.com

Robin with HealthPartners Health Plan
P.O. Box 1309
Minneapolis, MN 55440-1309
Telephone: 1-855-542-6922, 952-883-5000
Fax: 952-883-5666
Website: healthpartners.com/etfrobin

UnitedHealthcare
P.O. Box 29675
Hot Springs, AR 71903-9675
Telephone: 1-844-876-6175
Website: UHCRetiree.com/etf

WEA Trust
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