WISCONSIN PHYSICIANS SERVICE INSURANCE CORPORATION
ENROLLMENT FORM FOR STUDENTS AND THEIR DEPENDENTS

INSTRUCTIONS: Please complete the entire application. Please print using **black** ink.

LAKELAND COLLEGE

1. Reason for Application

Please indicate if you are:

❑ Full Time Student ❑ Part-Time Student ❑ Graduate Student ❑ International Student ❑ Other – Accelerated Programs

❑ Applying for Family Coverage ❑ Applying for Continuation Coverage

❑ Adding a Dependent: Name _____ Effective Date: _____

❑ Addition Due To: ❑ Marriage - Date _____ ❑ Birth - Date _____

❑ Addition Due To: ❑ Adoption - Date _____ ❑ Other/Date _____

2. Information About You (Applicant)

Student Name: _____ (Last / First) Social Security No: _____ Student ID: _____

Gender: ❑ Male ❑ Female Date of Birth: _____ Expected Date of Graduation: _____ (Month / Year)

Permanent Address: _____ (Number & Street / City / State / Zip / County)

Mailing Address: _____ (Number & Street / City / State / Zip / County)

Telephone Number: _____ E-Mail Address: _____

3. Information About Your Family (If enrolling dependents, please complete this section)

Last Name	First Name	MI	Gender	Birth Date	Relationship to Applicant

4. Payment Information

❑ Charge Full Amount: _____

❑ Visa: _____ ❑ MasterCard: _____

Expiration Date: _____

Authorized Signature: _____ Date: _____

OR

❑ Paid by Check Number: _____ Amount Paid: _____

Make check or money order payable to WPS or refer to the charge card authorization above to charge your premium to Visa or MasterCard. Mail this enrollment form along with premium payment to: **WPS Health Insurance**

P.O. Box 8190 • Madison, WI 53708-8190

Your cancelled check or credit card billing is your only receipt and notification of coverage. **It is the student's responsibility for timely renewal payments whether or not a renewal notice is received.**

5. Notice to Student/Signature

Coverage will be effective the date the correct premium is received by the Insurer or a representative of the Insurer or the effective date of the coverage period, whichever is later. By signing, the student acknowledges the following: (1) he/she has carefully read the brochure and elects to enroll as indicated on this enrollment form; (2) rates are not pro-rated other than as listed on this enrollment form; (3) he/she meets the eligibility requirements for this coverage as described in the brochure; and (4) if it is later determined that the student is not eligible, the premium will be refunded and coverage will not be in effect. **Premium will not be refunded except for ineligibility or entrance into the armed forces.**

I understand the policy is not renewable. 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) I, my spouse or any dependent(s) suffer as a result of any improper advice, action, or omission on the part of any health care provider.

Student's Signature: _____ Date: _____

6. Coverage Election – Please Check All Appropriate Boxes

Effective/Expiration Periods:	❑ Annual	❑ 08-01-2011 to 7-31-2012
	❑ Fall	❑ 08-01-2011 to 12-31-2011
	❑ Spring/Summer	❑ 01-01-2012 to 7-31-2012
	❑ Monthly Continuation	(former students only limited to the number of months eligible)

Premiums:	**Annual**	**Fall**	**Spring/Summer**
Student	❑ $1,380.00	❑ $579.60	❑ $800.40
Spouse	❑ $3,105.00	❑ $1,304.10	❑ $1,800.90
Dep. Child	❑ $2,415.00	❑ $1,014.30	❑ $1,400.70
Monthly Continuation:	Student - ❑ $172.50	Spouse - ❑ $388.13	Dep. Child - ❑ $301.88

To calculate your continuation rate, multiply the monthly rate stated above times the number of months purchased.
Number of months purchased _____.

7. Information About Other Medical Coverage

Will you or any family member(s) continue or maintain any other health coverage in addition to the insurance being applied for today?
❑ No ❑ Yes

List all coverage in the last 270 days. Failure to provide coverage information may result in a pre-existing condition limitation.

Policyholder Information	Name, Address and Phone Number of Insurance Company / Plan	Policy or Group Number	Type of Coverage	Type of Plan	Effective Date of Coverage	Cancellation Date
Name: ❑ Employee ❑ Spouse Date of Birth:			❑ Family ❑ Single	❑ Medical ❑ Dental		
Name: ❑ Employee ❑ Spouse Date of Birth:			❑ Family ❑ Single	❑ Medical ❑ Dental		

You have a right to request a certificate of creditable coverage from your prior plan. If necessary, we will assist you in obtaining a certificate from the prior plan. If you received a certificate of creditable coverage from your prior plan, please attach a copy to this enrollment form.