EPIC SPECIALTY BENEFITS

2018 EPIC BENEFITS+ ANNUITANT SPECIAL ENROLLMENT FORM

Enrollment period of October 2 – October 27, 2017

Coverage Effective January 1, 2018

Please print clearly or type - Submit form to EPIC Specialty Benefits

SECTION 1: APPLICANT INFORMATION

Annuitant Name (last, first, middle)		Email Address	
Street Address	City	State	Zip Code
Social Security Number or EPIC Benefits+ ID Number	Daytime Telephone Number	Date of Birth	Gender ☐ Male ☐ Female

SECTION 2: PLAN SELECTION (Check one)

Please indicate your choice to elect EPIC Benefits+ insurance with or without Vision coverage. If you currently have EPIC Benefits+, you may make changes based on your personal need.

Requested Coverage: ☐ Benefits+ with Vision ☐ Benefits+ without Vision

For Existing Members: ☐ Add Vision ☐ Term Vision ☐ Term Current Benefits+ Coverage

SECTION 3: SPECIAL ENROLLMENT GRADUATED DENTAL MAXIMUM

Members enrolling during the 2018 Special Enrollment will be subject to the following Dental graduated maximum benefit schedule.

Dental Maximum per member in calendar year

• 2018 is $750 • 2019 is $1000 • 2020 is $1,500 (full benefit amount) • 24 month waiting period on Orthodontics

SECTION 4: COVERAGE TO BE SELECTED (Check one below)

Select which coverage fits your specific needs. ☐ Single Coverage ☐ Annuitant + Spouse
☐ Annuitant + Child(ren) ☐ Family [Annuitant, spouse and child(ren)]

SECTION 5: COMPLETE THE FOLLOWING INFORMATION ONLY FOR INDIVIDUALS COVERED BY THE POLICY

Name	Date of Birth	Gender (M/F)	Social Security Number	Relationship to Applicant	Disabled (Y/N)	Tax Dep (Y/N)	Married
		☐M ☐F			☐Y ☐N	☐Y ☐N	☐Y ☐N
		☐M ☐F			☐Y ☐N	☐Y ☐N	☐Y ☐N

Beneficiary: Last Name: First Name: Middle Initial: Relationship:

**Please use additional paper if needed to list additional dependents or beneficiaries. There is also a Beneficiary Designation form at www.EPICBenefits.com*

SECTION 6: PREMIUM PAYMENT

This application for Benefits+ Coverage Insurance must be submitted to EPIC no later than December 1, 2017. Premium payments for continuation of coverage will be billed by EPIC and paid to EPIC.

You may elect to receive and pay your premium by mail: ☐ Annually ☐ Semi-Annually ($2.00 fee) ☐ Quarterly ($2.00 fee)

You may elect to have premiums deducted directly from your bank through Electronic Fund Transfer:

☐ Semi-Annually ☐ Quarterly ☐ Monthly

From: ☐ Checking - Include a voided check ☐ Savings - Provide: Account #_____ Routing #_____

Billing statements are not provide when electronic transfer is selected.

This authorization will remain in effect until I notify EPIC Specialty Benefits in writing of any change. My notification must allow EPIC Specialty Benefits and my financial institution reasonable opportunity to discontinue the premium deduction.

SIGNATURE – (Sign here and return completed application to EPIC) PO Box 8430, Madison, WI 53708

☐ I am applying for the coverage elected above. I understand that Wis. Stats. § 943.395 provides criminal penalties for knowingly making false or fraudulent claims on this form and hereby certify that, to the best of my knowledge and belief, the information is true and correct. I agree to the provisions of the plan. **I understand that once enrolled this coverage must remain in force for the full calendar year unless eligibility is lost.**

☐ **Cancel my coverage as of December 31, 2017. I understand that I must remain enrolled and pay required premium for the entire calender year. Termination of coverage due to nonpayment of premium may hinder future enrollment.**

Applicant Signature	Date
_____	_____