

# Application for Coverage



Wyoming Educators  
Benefit Trust

Medical  
 Dental

Claims Supervisor:



**WYOMING**

P.O. Box 2266  
Cheyenne, WY 82003

Initial Enrollment  
 Decline Coverage(s)  
 Add Dependent(s) to Existing Coverage

**DEDUCTIBLE:**  
 \$1,000

**PLEASE COMPLETE IN FULL, EVEN IF ADDING NEWBORN.**  
Date of Marriage/Civil Union (if applicable) \_\_\_\_/\_\_\_\_/\_\_\_\_  
Date Dependent Was Acquired \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Date of birth, adoption, etc.)

Please print, using black ink, and initial all corrections; do not use correction fluid or correction tape.

GENERAL INFORMATION		
NAME OF EMPLOYER	DATE EMPLOYED FULL TIME MM DD YYYY: ____/____/____	HRS WORKED PER WEEK
EMPLOYEE MARITAL STATUS <input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> CIVIL UNION	EMPLOYEE JOB TITLE	

**HEALTH COVERAGE ENROLLMENT OR DECLINATION**

I wish to enroll for the WEBT health coverage offered by my employer. I wish to cover:  
 Myself  Myself & My Spouse/Civil Partner  Myself & Dependent Child(ren)  
 Myself, Spouse/Civil Partner & Dependent Child(ren)  
 Myself Dental  Myself & My Spouse/Civil Partner Dental  Myself & Dependent Child(ren) Dental  
 Myself, Spouse/Civil Partner & Dependent Child(ren) Dental

I am declining my employer's WEBT health coverage on behalf of the following (print name and Social Security # for all individuals for whom you are declining): \_\_\_\_\_

I am declining due to:  the existence of other group coverage  
 the existence of other individual coverage  
 other reason(explain) \_\_\_\_\_

SIGN ONLY IF YOU HAVE DECLINED ANY COVERAGE. I have had the Enrollment Regulations of my employer's WEBT health coverage explained to me and I understand if I delay in making application for myself and/or any eligible dependents until after the initial period of eligibility I and/or my eligible dependents will only be able to enroll during the annual open enrollment period at which time we will be subject to the late enrollee provisions as stated in my Employer's Benefit Document. I further understand that I and/or any eligible dependents may be eligible later for a special enrollment as provided by applicable law.

Signature \_\_\_\_\_ Date \_\_\_\_\_

FAMILY INFORMATION				
RELATIONSHIP	FAMILY MEMBER'S NAME - List all family members to be covered (attach additional page if necessary) Last First MI	SEX	DATE OF BIRTH MM DD YYYY	SOCIAL SECURITY #
EMPLOYEE				
SPOUSE/CIVIL PARTNER				
STREET ADDRESS	CITY	STATE	ZIP	HOME TELEPHONE
MAILING ADDRESS	CITY	STATE	ZIP	WORK TELEPHONE

**For Blue Cross Blue Shield Office Use Only**

Class \_\_\_\_\_ GRP/Roll \_\_\_\_\_ AD \_\_\_\_\_ Probationary Period \_\_\_\_\_  
 OED \_\_\_\_\_ BCBS \_\_\_\_\_ DCS \_\_\_\_\_

## REQUIRED INFORMATION RELATED TO HEALTH COVERAGE

Please complete the following for ALL individuals named on this application who currently have, or who had in the past 60 days, other health coverage. Attach extra pages which you have signed and dated, if necessary.

Policyholder's Name: \_\_\_\_\_ Covered Individuals: \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

Policy #: \_\_\_\_\_ Coverage Began (MM/DD/YY): \_\_\_\_\_ Ended (MM/DD/YY): \_\_\_\_\_

If still in effect, will the coverage described above be cancelled when this coverage becomes effective?  Yes  No

If yes, give reason for cancelling coverage \_\_\_\_\_

If no longer in effect, did the coverage described above terminate for ANY of the following reasons: Termination of employment; Termination of the employer's contribution to coverage; Termination of the other health plan's coverage with the employer; Death of a Spouse/Civil Partner; Divorce or Legal separation?  Yes  No

- A. I understand that upon acceptance of this application, coverage will become effective on the date established by the WEBT and that the Benefit Document, together with this application and attachments, if any, shall constitute my/our entire agreement with the Wyoming Educators' Benefit Trust.
- B. I affirm that I have reviewed all answers given on this application and, regardless of whether any other individual has filled out the answers for me; I verify that the answers are true and complete. I REALIZE THAT ANY ACT, PRACTICE, OR OMISSION I HAVE PERFORMED THAT CONSTITUTES FRAUD OR INTENTIONAL MISREPRESENTATION OF MATERIAL FACT ASKED FOR ON THIS APPLICATION WILL RENDER THE CONTRACT NULL AND VOID OR SUBJECT TO CANCELLATION, RESCISSION, OR TO DISALLOWANCE OF THE INDIVIDUAL ABOUT WHICH THE FRAUDULENT ACT, PRACTICE, OMISSION, OR INTENTIONAL MISREPRESENTATION OF MATERIAL FACT OCCURRED.
- C. I apply for coverage with the Wyoming Educators' Benefit Trust under the terms and conditions as stated in the Benefit Document, including the coordination of benefits provision.

I HAVE READ AND UNDERSTAND ITEMS A - C ABOVE.

SIGN BELOW ONLY IF YOU ARE APPLYING FOR COVERAGE.

APPLICANT'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**APPLICATION WILL NOT BE PROCESSED IF RECEIVED MORE THAN 60 DAYS AFTER DATE OF SIGNATURE**

**IMPORTANT: Please be certain you have answered ALL questions on this application.**