WEA trust
45 Nob Hill Road | Madison, Wisconsin 53713
800.279.4000 WEAtrust.com

WEA-MedPlus Enrollment Form

Requested Effective Date: _____ / _____ / _____

SECTION 1 – General Applicant Information and Election

Coverage typically begins the first of the month following the date of receipt of this enrollment form.

First Name	Middle Initial	Last Name
Street Address		
City	State	Zip Code
Primary Phone	Secondary Phone	
Social Security Number	Date of Birth	
E-mail Address	Gender ☐ M ☐ F	

Are you enrolling in "*self*" or "*self and spouse*" or "*self and domestic partner*" coverage?

- ☐ Self
- ☐ Self and Spouse *(please provide spouse's information below)*
- ☐ Self and Domestic Partner* *(please provide domestic partner's information below)*

Spouse or DP Name	Spouse or DP Gender ☐ M ☐ F
Spouse or DP Social Security Number	Spouse or DP Date of Birth
Spouse or DP Phone	Spouse or DP E-mail Address

SECTION 2 – Eligibility

*To be eligible for coverage under the WEA-MedPlus plan, each person applying must be age 65 or older and meet **all** of the following criteria. For each person applying, confirm that the following criteria are met.*

I am retired from all full-time employment.	Self ☐	Spouse or DP ☐
I am NOT working independently as a contractor, consultant, or part-time for an employer covered under a WEA Trust group plan.	Self ☐	Spouse or DP ☐
I am enrolled in Medicare Part A and Medicare Part B	Self ☐	Spouse or DP ☐
I am NOT enrolled in a Medicare Advantage (Part C) plan.	Self ☐	Spouse or DP ☐

In addition to the above requirements, you or your spouse or domestic partner must meet at least one of the following criteria. Please check all that apply.

I, or my spouse or DP, was a WEA Trust health plan subscriber at some point during the past 10 years.	Self ☐	Spouse or DP ☐
I, or my spouse or DP, am a member of the WEAC Retired class or was a WEAC member at some point during the past 10 years	Self ☐	Spouse or DP ☐
I, or my spouse or DP, was an employee of any Wisconsin unit of government at some point during the past 10 years.	Self ☐	Spouse or DP ☐
I, or my spouse or DP, was an employee of a Wisconsin unit of government for a cumulative period of at least 10 years. The 10 years do not need to have been consecutive.	Self ☐	Spouse or DP ☐

*Domestic Partner Attestation Form is required

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SECTION 3 – Additional Information

Please provide Medicare and current health insurance information for you and your spouse or domestic partner (if applicable).

	Self	Spouse or Domestic Partner
Medicare Number		
Part A Effective Date		
Part B Effective Date		
Are you and/or your spouse or domestic partner currently covered by a health insurance policy other than Medicare?	Yes ☐ No ☐	Yes ☐ No ☐
Name of Insurer		
Policy Number		
Group Number		
Effective Date of Group Coverage		
Termination Date of Group Coverage		

SECTION 4 – Billing

ACH (Automated Clearing House) withdrawal is a service provided by WEA Trust that allows you to have your monthly premium automatically deducted from your bank account. We will deduct your premium on the 20th of each month.

(If the 20th of the month falls on a weekend or holiday, the deduction will occur on the next business day).

Do you currently use ACH withdrawal with WEA Trust?

Yes ☐	No ☐
Would you like to *continue* using ACH withdrawal to pay the premium for your new WEA-MedPlus plan? Yes ☐ No ☐	Would you like to *set up* ACH withdrawal to pay the premium for your new WEA-MedPlus plan? Yes ☐ No ☐
Would you like to use the *same* banking information we have on file to pay your premium? Yes ☐ No ☐	If **yes**, please fill out the banking information below and submit a check for the first month's premium along with this enrollment form.
If **yes**, we do NOT need a check for the first month's premium. We will continue to pull from your current account for the updated WEA-MedPlus monthly premium. Please do not fill out the banking information below.	If **no**, please do not fill out the banking information below. You will be sent a monthly invoice for your WEA-MedPlus premium. Please include a check for the first month's premium along with this enrollment form.
If **no**, please fill out the banking information below and include a check for the first month's premium along with this enrollment form.	

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SECTION 5 – Banking Information

For checking accounts, attach a voided check to this form to confirm your bank routing and checking account number. For savings accounts, attach a letter from your bank that includes their routing number and your savings account number.

Account Holder Name *(name as shown on bank account)*		
Name of Financial Institution		
Street Address of Financial Institution		
City	State	Zip Code
Type of Account	☐ Checking	☐ Savings
Bank Routing Number	Bank Account Number	

SECTION 6 – ACH Authorization and Certification

I authorize WEA Trust and the bank named above to initiate variable entries to my checking/savings account. This authority will remain in effect until I notify you or the bank, in writing, to cancel it in a reasonable amount of time to act on it.

I attest the information provided is accurate and complete. I have read and understood the information regarding the WEA-MedPlus plan. I understand the choice I have made and certify that all information I have provided is complete and accurate. I further understand that if I am leaving a WEA Trust employer group health plan, I will not be able to return to that plan.

Signature of Applicant Date

Signature of Spouse or Domestic Partner *(if applicable)* Date

Note: Some portions of this document can be filled out electronically, but you will have to print out, sign, and return the form to WEA Trust.

Please enclose your first month's premium so we can process your application *(if applicable).*

WEA Trust
Attn: Accounting
45 Nob Hill Road
Madison, WI 53713

If you have any questions about the WEA-MedPlus plan,
please call our Customer Service Department at 1.800.279.4000.