WEA trust
P.O. Box 21538 | Eagan, Minnesota 55121-5038
800.279.4000 WEAtrust.com

WEA-MedPlus Enrollment Form

SECTION 1—General Applicant Information and Election

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

Last Name _____ First Name _____ Middle Initial _____

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 for self or self and spouse coverage? **Requested Effective Date** _____

- ☐ Self
- ☐ Self and Spouse (please provide spouse's information)

Spouse Name _____

Spouse Date of Birth _____ Spouse Social Security Number _____

Gender ____M _____F

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, please confirm that the following criteria are met.*

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

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

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

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SECTION 3—Additional Information Required

1. Please provide your Medicare number and your Medicare Part A and Part B effective dates.

Self Medicare Number _____ **Spouse** Medicare Number _____

Medicare Part A _____ Medicare Part A _____

Medicare Part B _____ Medicare Part B _____

2. Are you and/or your spouse currently covered by a health insurance policy other than Medicare?

Self ☐ Yes ☐ No **Spouse** ☐ Yes ☐ No

Name of Insurer _____

Policy No./Group No. _____ Effective Date of Coverage _____

When did/will this coverage end? _____

SECTION 4—Certification

I attest the information provided is accurate and complete.
I have read and understand 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.

Applicant Signature _____ Date _____

Spouse's Signature (if applying) _____ Date _____

Some portions of this document can be filled out electronically, but you will have to print out, sign, and return the form to the Trust. **Please enclose your first month's premium so we can process your application**.

WEA Trust
Attn: Accounting
P.O. Box 21538
Eagan, MN 55121-5038

**If you have questions about the WEA-MedPlus plan,
please call our Customer Service Department at 800. 279.4000.**