

APPLICATION FOR COVERAGE



Complete (print) and sign application in black or blue ink. Send application and a check payable to WPS in the envelope provided. Please keep the brochure for your files. **Please Note: You must be a Wisconsin resident to apply for IPP.**

Applicant's Name (Print last, first, middle initial)		Social Security Number
Street Address		Home Phone Number ()
City	ZIP Code	

Applicant's Gender Female Male Date of Birth _____ Occupation _____

How did you learn about The Instant Protection Plan?

Covered Dependents			Date of Birth	Gender	Social Security Number
First Name	Middle Initial	Last Name	Mo/Day/Yr	M/F	
Spouse					
Child(ren)					

Have you, your spouse, or any dependent named on this application had the WPS Instant Protection Plan before? Yes No
If so, when? _____

1. Do you, your spouse, or any dependent named on this application have any hospital, major medical, group health, or other medical insurance coverage that will not be terminated prior to the effective date of this policy? Yes No
2. Are you, your spouse, or any dependent currently pregnant, an expectant mother or father, or disabled (even if dependent coverage is not being requested)? Yes No
3. Have you, your spouse, or any dependent named on this application ever been denied health insurance due to health reasons? Yes No
4. Within the past five years, have you, your spouse, or any dependent named on this application: (a) been diagnosed with, treated for, had medication prescribed for, or had symptoms of cancer, heart or circulatory disorders, stroke or transient ischemic attack (TIA), alcohol or drug abuse, eating disorder, liver disease, pancreas disorder, diabetes, multiple sclerosis, fibromyalgia, systemic lupus, emphysema, chronic obstructive pulmonary disease, cystic fibrosis, Crohn's disease, ulcerative colitis, disorder of the bone marrow; (b) had or been considered for an organ or bone marrow transplant; (c) been treated for, or diagnosed by a medical professional as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC); (d) had any alcohol or drug-related arrest? Yes No
5. Within the past five years, have you, your spouse, or any dependent named on this application: (a) had any medical condition for which future testing, surgery or hospitalization is scheduled, planned, recommended or warranted; (b) had signs or symptoms of an undiagnosed illness or an injury for which it may be necessary to seek medical services or treatment in the future? Yes No
6. Do you, your spouse, or any dependent named on this application engage in any of the following activities: farming; racing a motor vehicle, boat or snowmobile; sky diving; hang gliding; flying an aircraft? Yes No

Note: This plan cannot be issued if you answered yes to any of the above questions.

7. How many days of coverage are you requesting? (Must be at least 30 days, but not more than 185 days.) _____ days. Please choose payment option:
 30-185 days Prepay the entire coverage period with a personal check.
 30-185 days Credit/Debit Card—prepay the entire coverage period. Please complete sections A. and B. of the Credit/Debit Card or Automatic Withdrawal Payment Authorization Form.
 150-185 days ACH—Monthly Bank Draft. Please complete sections A. and C. of the Credit/Debit Card or Automatic Withdrawal Payment Authorization Form.
8. Requested Effective Date (check one): Day following postmark date
 _____ (Fill in date requested; must be after postmark date)
If original envelope isn't included with application, coverage will be effective the day we receive the application.
9. Deductible (Plan) Option (check one): \$250 \$500 \$1,000 \$1,500

- For coverage periods between 30 and 185 days NOT utilizing ACH: Please submit a check or credit/debit card authorization form equal to the entire premium amount you figured on the **How to Calculate Your Premium** page in the attached brochure.
- For coverage periods of 150 to 185 days utilizing the ACH option: Please submit a personal check equal to the sum of one month's premium and any partial month's premium. **AMOUNT ENCLOSED: \$** _____

I understand the Instant Protection Plan will not provide benefits for any illness or injury occurring before the effective date of the policy. I understand the policy is not renewable. I further understand and agree that WPS, 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. I have reviewed the WPS IPP brochure and have determined that this policy is suitable for me.

Applicant's Signature Angie Halverson Schroeder & Associates 724 East Main St. Stoughton, WI 53589	Spouse's Signature (if applying for coverage) Date _____ _____ 398428468A
WPS Agent/WPS Representative	WPS Agency Name and Number (if applicable)