

PLAN		DEDUCTIBLE OPTION		COVERAGE EFFECTIVE	
<input type="checkbox"/> Single	<input type="checkbox"/> Family	<input type="checkbox"/> \$ 500 ind. / \$1000 fam.		THE FIRST DAY OF:	
<input type="checkbox"/> Employee + Spouse	<input type="checkbox"/> Employee + Child(ren)	<input type="checkbox"/> \$1000 ind. / \$2000 fam.		Month: _____ Year: _____	
		<input type="checkbox"/> \$2400 ind. / \$4000 fam.			
		<input type="checkbox"/> \$3000 ind. / \$6000 fam.			
APPLICANT'S LAST NAME	FIRST NAME	M.I.	SEX	DATE OF BIRTH	SS#
STREET ADDRESS		CITY	STATE	ZIP CODE	
PHONE NUMBER	MARITAL STATUS				
( ) -	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	<input type="checkbox"/> Widow or Widower	
Have you previously been covered under the WELS VEBA plan? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes, please indicate the policyholder's Social Security#: _____					
GROUP TERM LIFE/AD&D BENEFICIARY			RELATIONSHIP TO INSURED		
EMPLOYMENT START DATE: ____/____/____			CALLED/EMPLOYED BY (CONG. NAME):		
PLEASE CHECK THE APPROPRIATE BOX:			CITY, STATE & ZIP CODE:		
<input type="checkbox"/> Pastor	<input type="checkbox"/> MLC / WLS Student	_____			
<input type="checkbox"/> Male Teacher	<input type="checkbox"/> Vicar	_____			
<input type="checkbox"/> Female Teacher	<input type="checkbox"/> Lay Worker	_____			
<input type="checkbox"/> Dependent	<input type="checkbox"/> Spouse of Worker	_____			

Please complete this section if you are applying for family, employee + spouse, or employee + child(ren) coverage.  
List all persons to be included! {Do not include yourself (the worker)}.

LAST NAME (SPOUSE)	FIRST NAME	M.I.	SEX	DATE OF BIRTH	SS#
DEPENDENT CHILDREN					

DEPENDENT CHILDREN WHO ARE AGE 19 OR OVER AND ARE UNMARRIED FULL-TIME STUDENTS						
LAST NAME	FIRST NAME	M.I.	SEX	D.O.B.	SS#	SCHOOL NAME & GRADUATION DATE

**THE FOLLOWING INFORMATION IS USED TO COORDINATE BENEFITS WHICH MAY BE AVAILABLE TO YOU THROUGH TWO DIFFERENT GROUP INSURANCE PROGRAMS.**

IS ANYONE NAMED IN THIS APPLICATION COVERED BY ANOTHER GROUP HEALTH INSURANCE PROGRAM? <input type="checkbox"/> YES <input type="checkbox"/> NO                      (IF YES, PLEASE COMPLETE THE SECTION BELOW).		
NAME OF INSURED		
EMPLOYER	PHONE NUMBER	
INSURANCE CARRIER'S NAME	PHONE NUMBER	
ADDRESS		
GROUP NUMBER	EFFECTIVE DATE	TERMINATION DATE
TYPE OF POLICY: <input type="checkbox"/> Group <input type="checkbox"/> Individual		
COVERAGE LEVEL: <input type="checkbox"/> Member Only <input type="checkbox"/> Family		
TYPE OF COVERAGE: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision		
COB RULE: BIRTHDAY ____/____/____                      GENDER: _____                      OTHER: _____		

<b><i>PLEASE SIGN BELOW INDICATING THAT ALL THE INFORMATION SHOWN ON THIS APPLICATION IS CURRENT AND ACCURATE</i></b>	
<b>SIGNATURE:</b> _____	<b>DATE:</b> _____

PLEASE RETURN TO:  
WELS BENEFIT PLANS OFFICE  
2949 N. MAYFAIR ROAD, 2<sup>nd</sup> Floor  
MILWAUKEE, WI 53222

**WELS LONG TERM DISABILITY  
INCOME REPLACEMENT COVERAGE**

PLEASE COMPLETE AND RETURN IN THE ENCLOSED ENVELOPE TO:  
WELS BENEFIT PLANS OFFICE  
2949 N. Mayfair Road, #116  
Milwaukee, WI 53222-4392

Name of Calling/Hiring Body: \_\_\_\_\_

Address of Calling/Hiring Body: \_\_\_\_\_

Street Address

City

State

Zip Code

Service Start Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

PLEASE PROVIDE THE FOLLOWING COMPENSATION INFORMATION  
(Please note the "Instructions/Key" below)

<u>Soc. Sec. No.</u>	<u>Last Name,</u>	<u>First Name,</u>	<u>M.I.</u>	<u>(1) Occupation Code</u>	<u>(2) Annual Salary</u>	<u>(3) Annual Housing</u>	<u>(4) Annual Utilities</u>
_____	_____	_____	_____	_____	_____	_____	_____

**INSTRUCTIONS/KEY**

- (1) "Occupation Code":  
Please enter either "Pastor", "Teacher", or "Lay"; if the Occupation Code is "Lay", please also enter one of the following designations:  
 (A) - Secretary, Clerk, Administrator, Manager;  
 (B) - Cook or Food Service Worker; or  
 (C) - Maintenance Worker, Janitor, Bus Driver.
- (2) "Annual Salary":  
Please enter the annual base salary; please do not include housing, utilities, or car allowances.
- (3) "Annual Housing":  
If a Housing Allowance is provided in the form of a cash payment, please enter the actual annual amount.  
If housing is provided in the form of a teacherage or parsonage, please enter "P".  
If no Housing Allowance or housing is provided, please leave this line blank.
- (4) "Annual Utilities":  
If a Utilities Allowance is provided in the form of a cash payment, please enter the actual annual amount.  
If utilities are provided by the calling/hiring body, please enter "P".  
If no Utilities Allowance or utilities are provided, please leave this line blank.

# Information Sheet for 2010 WELS VEBA Plan Options

## 2010 VEBA Plan Options:

Plan	Deductible		Out-of-Pocket Maximum		Co-Insurance Percentage
	Individual	Family	Individual	Family	
Plan 1	\$500	\$1000	\$1500	\$3000	90% in-network 70% out-of-network
Plan 2	\$1000	\$2000	\$3000	\$6000	85% in-network 70% out-of-network
* Plan 3	\$2400	\$4000	\$5000	\$10000	80% in-network 70% out-of-network
Plan 4	\$3000	\$6000	\$6000	\$12000	80% in-network 50% out-of-network

\* Plan 3 is an HSA-compliant high deductible health plan (HDHP)

## Deductible/Coinsurance Explanation

(examples below based on Plan Option 1 – amounts differ for Plan Options 2, 3 and 4 – please see above chart for more details)

**Single Plan:** After member meets the \$500 deductible, the member will pay for \$1,000 coinsurance (10% of \$10,000 for in-network providers, 30% of \$3,333 for out-of-network providers).

**Family/Employee plus Spouse/Employee plus Child(ren) Plan:** \$500 deductible for each family member or an aggregate of \$1,000 deductible for entire family. Each family member is then responsible for an additional \$1,000 in coinsurance (10% of \$10,000 for in-network providers, 30% of \$3,333 for out-of-network providers) OR the family in aggregate is responsible for an additional \$2,000 in coinsurance (10% of \$20,000 for in-network providers, 30% of \$6,666 for out-of-network providers).

**Please choose one of the options and check the proper box on the “Health Enrollment Form.”**

## **We suggest the following procedures:**

1. Discuss with your calling/hiring body which deductible option they will provide.
2. Determine if you wish to have a lower deductible for which you would reimburse your calling/hiring body (we are not able to bill you for any difference in premium).

## **Your deductible choice will be in effect for the entire calendar year except as follows:**

If you accept a call/position to a congregation with a different deductible than you previously had, you may change your deductible if you notify us of your desire to change within 60 days of accepting the new call or position. The deductible can be made effective for the subsequent month.

**Note:** A worker who remains at the same calling/hiring body will be able to change (increase or decrease) their deductible at the beginning of each calendar year.

**Reminder:** Please check with your calling/hiring body as to which deductible option they will provide BEFORE you make your plan option choice. You still have the right to choose a lower deductible option but may have to pay the difference in premium.

*If you have any questions, please contact the WELS Benefit Plans Office at 414-256-3860 or bpo@sab.wels.net.*

**WELS VEBA GROUP HEALTH CARE PLAN  
NOTICE OF SPECIAL ENROLLMENT RIGHTS**

If you are declining (or have declined) enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 60 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days after the marriage, birth, adoption, or placement for adoption.

You may also request enrollment within 60 days of the following events:

- You accept a new call or position with a new WELS/ELS Sponsoring Organization
- You experience a change in Medicaid/Children's Health Insurance Program (CHIP) status
- Pursuant to a Qualified Medical Child Support Order

To request special enrollment or obtain more information, contact:

Wisconsin Evangelical Lutheran Synod  
Benefit Plans Office  
2949 North Mayfair Rd., 2nd Floor  
Milwaukee, WI 53222  
1-414-256-3860