

Employer Information			
Legal Name of Employer _____			
Legal Status: <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> Limited Liability Company <input type="checkbox"/> Other _____			
Other Name(s) of Employer _____			
Principal Address _____			
City _____ State _____ County _____ Zip _____			
Billing Address (if different from above) _____			
City _____ State _____ County _____ Zip _____			
Telephone Number _____ Fax Number _____ Years in Business _____			
Tax ID Number _____ Nature of Business _____ SIC Code _____			
Chief Executive _____			
Insurance Contact Person _____ E-mail Address _____			
Are you including affiliates or subsidiaries? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please give names, addresses and Tax ID Numbers below. _____			
Are you an Applicable Large Employer (ALE)? <input type="checkbox"/> Yes <input type="checkbox"/> No			
COBRA Information			
Is the Employer legally required to provide COBRA Continuation Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please give names of persons currently on COBRA or within COBRA election period (attach supplemental list if necessary, initialed by signatory).			
Name	Social Security Number	Qualifying Event-Describe	Effective Date of Coverage
Other Important Employee Information			
Employee waiting period: <input type="checkbox"/> None <input type="checkbox"/> 30 Days <input type="checkbox"/> 60 Days			
Number of employees applying for coverage who live outside the state in which company is located: _____			
Coverage will be effective on the first day of the month following completion of the waiting period designated above.			
Workers Compensation			
Would you like the 24-Hour Work-Related Coverage Option? <input type="checkbox"/> Yes <input type="checkbox"/> No (On-the-job health coverage is only available for employees not eligible for or not covered by Workers' Compensation.)			
Name of current Workers' Compensation Carrier _____			
Policy Number _____			

Appointment of Authorized Representative

The following named individual(s) is/are authorized to act on behalf of the Plan Sponsor:

Primary Name (Please Print)_____
Position/Title_____
Signature_____
Secondary Name_____
Position/Title_____
Signature_____

Privacy Officer(s) Assignment

Authorized Privacy Officer(s)

Name (Please Print)_____
Name (Please Print)_____
Name (Please Print)_____
Name (Please Print)_____

SafeGuard Wisconsin shall be entitled to rely on the above-named individual(s) for instructions.

Employer Name_____

Plan Sponsor (or authorized representative)_____

Date_____