

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			
Are retirees covered for medical? (Must have a min. of 20 covered lives) <input type="checkbox"/> Yes <input type="checkbox"/> No Number of retirees to be covered: _____			
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. Retirees are subject to Retiree Class Rules.			
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_____