ASA
Agri-Services Agency
Leaders in Agricultural Insurance
P.O. Box 228 Athens, Pa 18810
Phone: 800-539-9370 / Fax: 570-265-7758

Farmers' Health Cooperative of Wisconsin

[ ] New Enrollment **[ ] Coverage Change** **[ ] Requested Effective Date / /**

Section 1- Applicant Information

Name (First, Middle initial, Last)	Sex	Birth date	Marital Status	Social Security #
	[ ] M [ ] F	/ /	[ ] Single [ ] Married [ ] Divorced/Legally Separated [ ] Widowed	

Address (Indicate mailing address, if different)	City	State	Zip Code	County	DFA Member?
					☐ Yes ☐ No

Home Phone	Business Phone	Fax#	Email
( )	( )	( )	

Employer Name	Occupation	Date of Hire	# Hours/ Week

Section 2- Dependent Information

First Name	MI	Last Name^	Social Security #	Relationship	Sex	Date of Birth	Legally Handicapped?
				Spouse	[ ] M [ ] F		[ ] Yes [ ] No
				[ ] Child [ ] Stepchild [ ] Other	[ ] M [ ] F		[ ] Yes [ ] No
				[ ] Child [ ] Stepchild [ ] Other	[ ] M [ ] F		[ ] Yes [ ] No
				[ ] Child [ ] Stepchild [ ] Other	[ ] M [ ] F		[ ] Yes [ ] No

For any child 18 years old or over listed in Section 2:
Child married? [ ] No [ ] Yes
If Yes, then complete Section 2A

Section 2A:
Child claimed on your tax return? [ ] No [ ] Yes
If Yes, please provide child's name here:_____

^If spouse has a different last name than the applicant, a copy of the marriage certificate is required. For a child with a different last name ASA reserves the right to request additional documentation.

Section 3-Requested Coverage

Add:	**Change due to:**
[ ] New Hire [ ] Existing Employee [ ] Dependent	[ ] Marriage [ ] Birth/Adoption [ ] Divorce/Legal Separation [ ] Death **Event Date:** / /

Section 4-Coverage and Enrollment Selection

Coverage Selection (Choose One):				Enrollment Selection
POS Health Plans	**HSA Health Plans**			**Choose One**
[ ] $300 Deductible	[ ] $2,500 Deductible			[ ] Individual
[ ] $500 Deductible	[ ] $5,000 Deductible			[ ] 2-Person
[ ] $1,000 Deductible				[ ] Family
[ ] $2,500 Deductible				

Section 5-Payment Information

Premiums will be paid by:

[ ] Sponsor/Employer [ ] Subscriber/Self

Method of Payment:

[ ] Direct Bill Quarterly [ ] Direct Bill Monthly

[ ] Monthly milk check deduction **(Must Complete Section 6)**

[ ] Pre-Authorized Monthly Bank Account Withdrawal
(Additional forms will be sent to you)

Section 6- Deduction Authorization

I understand the premium as quoted includes an administrative fee per contract month, payable to Agri-Services Agency, LLC or its designee for administrative and claims service rendered to policyholders.

I hereby authorize that a deduction be made monthly from amounts due me, from any milk check, hauler check, salary or remuneration check, or pre authorized bank withdrawal, a sum sufficient to pay or prepay the advance monthly premiums and any sums owing or becoming due as determined by the insurance provider (company) for health insurance coverage as provided for the above-named insured(s).

CO-OP Name: _____

CO-OP MEMBERSHIP/CONTRACT # (If Applicable) _____

DFA MEMBERS: Council # _____

CO-OP Payee Code: _____

AUTHORIZED PERSON - SIGN HERE

X_____Date_____

Section 7-Medicare Information (Copy from Medicare Health Insurance Card)

1. Do you or someone to be covered have Medicare?
   [ ] No (skip to Section 8) [ ] Yes-answer the following:
2. Name of person with Medicare:_____
3. Reason for Medicare coverage: [ ] Age (65 or over) [ ] Disability
4. Medicare Claim No._____
5. Effective Dates For: Month Day Year
   Hospital Insurance (Medicare A) _____/_____/_____
   Medical Insurance (Medicare B) _____/_____/_____
6. Are you actively employed? [ ]Yes [ ]No Retirement Date:_____/_____/_____

Section 8-Application for Insurance

I hereby apply for coverage as indicated through Agri-Services Agency (ASA), with insurance coverage provided by Anthem. This constitutes an application for membership in Agri-Services, LLC, a wholly owned subsidiary of Dairylea Cooperative Inc. I understand coverage will be effective the first of the month following the receipt of this signed application in accordance with any employer waiting period. Required documentation must accompany the application. All information must be received by the monthly filing deadline.

I understand that I cannot change coverage or deductible options until the next Open Enrollment period of my policy, except upon the occurrence of a Qualifying Event. Approved Qualifying Events are: **(1)** marriage / divorce, **(2)** birth / adoption of a dependent child, **(3)** death of my spouse / dependent, **(4)** a change in my employment status / my spouse's employment status **(5)** a significant change in my employer-sponsored health insurance plan / my spouse's employer-sponsored health insurance plan.

I hereby represent that all information furnished by me on this form is true and complete to the best of my knowledge.

APPLICANT SIGNATURE - SIGN HERE:

X_____Date:_____

E-mail address:_____

Section 9- Existing Coverage (Applies Only to New Enrollments)

Do you currently have (or have you had) medical insurance coverage within the last year?

[ ] **No** Skip the remainder of Section 9

[ ] **Yes** Provide ASA with your Certificate of Creditable Coverage.

Current Carrier: _____

ASA will count each day you were covered under the creditable coverage towards meeting your waiting period, provided there is not a lapse of 63 or more days between the creditable coverage and your enrollment date for coverage under this contract. Without this certificate, or if there is a lapse of more than 63 days, you must wait 330 days before benefits are available for services in connection with any disease, illness, ailment or other condition for which, within 6 months before your enrollment date for coverage, medical advice, diagnosis, care or treatment was recommended or received. The waiting period is 30 days for the removal or tonsils and adenoids; maternity care is excluded from the waiting period provision.)

Section 10 - Broker Information

Broker/Sales Person:_____

Please Print Name