



Dean Health Plan, Inc.
a subsidiary of Premier Medical Insurance Group
CONVERSION APPLICATION
 Please print and complete in ink

PO Box 56099
 Madison, WI 53705
 (800) 279-1301

Applicant Name (Last, First, Middle)			FOR DHP USE ONLY:	Plan No.	Effective Date
Mailing Address:			City, State, Zip:		
County:	Home Phone No.				
COVERAGE DESIRED: <input type="checkbox"/> Single <input type="checkbox"/> Family <input type="checkbox"/> Couple (Applicant/Spouse) <input type="checkbox"/> Limited Family (Applicant/Child(ren)) COMPLETE THE FOLLOWING FOR ALL PERSONS APPLYING:					
NAME: Last, First & Middle	Sex	Relationship to Applicant	Social Security No. Birth Date	Primary Care Physician or Clinic (PCP) (if applicable)	FOR DHP USE ONLY:
		Self	- - / /		PCP
		Spouse	- - / /		
			- - / /		
1. The conversion policy will replace or succeed your current coverage. Please list your current policy No. _____ Type of Coverage (group, individual) _____ Group Name (if applicable) _____					
2. Are you or any family members listed above covered by another DHP policy or by any other health insurance policy? <input type="checkbox"/> Yes <input type="checkbox"/> No Name(s) _____ Policyholder's Birthdate _____ Insurance Co. _____ Phone No. _____ Policy No. _____ Effective Date _____ If your dependent's other health insurance is determined by a court order, please attach a copy of the order (e.g., divorce decree).					
3. When this policy becomes effective, will you or any family members listed above be covered by Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No Name _____ Medicare No. _____ Name _____ Medicare No. _____					
4. On what day will your current DHP Coverage end?					
5. Do you reside at the above address for at least 9 months of any year? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No", please explain residency and length of time at each residence.					
6. Do you or any other family members have an advance directive (living will or durable power of attorney for health care)? <input type="checkbox"/> Yes <input type="checkbox"/> No Name(s) _____					

Please read the "TERMS AND CONDITIONS" section, on the reverse side, before you sign this Application.

 Applicant's Signature and Date Signed

 Spouse's Signature and Date Signed

**In addition, please return one copy of the "NOTICE TO APPLICANT" with this Application.
 This notice is located in your conversion packet.**

TERMS AND CONDITIONS

1. By signing this Application, I understand and agree that: **(a)** All statements and answers I have given are complete and true to the best of my knowledge and belief; **(b)** the insurance I hereby apply for will be effective only when Dean Health Plan, Inc. (**DHP**) approves this Application. Evidence of such approval will be issuance of ID card(s) and policy. The effective date will be the date shown on the I.D. card issued; and **(c)** the Social Security numbers I have provided may be used for I.D. purposes. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an Application for insurance is guilty of a crime and may be subject to fines and/or imprisonment under *Wis. Stat.* 943.395. I further understand that, in the event of fraud or misrepresentation, claims may be denied in whole, or in part, and coverage may be rescinded. I also understand and agree that I authorize any physician, medical practitioner, hospital, clinic, medically-related facility, or other institution who provides treatment or service to me, my spouse and dependents covered under this Application, to disclose any medical and service information to DHP or its representatives. All such information will be used for the purposes of quality assurance, quality improvement, utilization and medical management projects, studies and activities for the period of enrollment and coverage under this Application.
2. All statements and answers in this Application are representations made by me on behalf of myself and other persons named in the Application, if any, to induce the issuance of the contract(s) applied for. The contents of this Application are to be solely relied upon by DHP. Coverage may be accepted or declined. DHP reserves the right, for two years following the original effective date, to retroactively void or rescind this policy if the Application includes any misstatements. The two year limitation does not apply to fraudulent misstatements made in the Application.
3. I, the undersigned, on behalf of myself and my dependents, if any, named in this Application, agree to cooperate in providing DHP with any information needed to process this Application.
4. This Application, when approved, and any endorsement, amendment or rider thereto, will be made part of the contract(s) applied for.
5. I understand that an insurance agent or broker cannot modify, waive or change in any way this Application, any requirement imposed by DHP, nor bind coverage or guarantee approval of this Application. No person, except an officer of DHP, is authorized to vary or modify a contract. I further understand and agree that DHP, its directors, officers, employees, and agents shall not be liable for any injury, damage or expense (including attorney's fees) that I or any of my dependents suffer as a result of any improper advice, action or omission on the part of any health care provider.



1277 Deming Way, Madison, WI 53717
(800) 279-1301 • TTY (608) 827-4086