



Health Insurance Risk-Sharing Plan

1751 W. Broadway – P.O. Box 8961 – Madison, WI 53708-8961
(800) 828-4777 or (608) 221-4551

Choice of Coverage Request - HIRSP

READ THE FOLLOWING BEFORE COMPLETING THIS FORM

This offer is not available to Health Insurance Risk-Sharing Plan (HIRSP) Medicare Supplement members.

Before you decide to change your plan coverage, we suggest you review: your financial situation, the cost of medical services you use in one year, the amount of the plan's deductible, premium rates, and the additional information in the attached memorandum. Complete the bottom of this form and return it to HIRSP only if you decide to change your plan coverage.

Completed form must be received by HIRSP before November 1, 2011.

Note: Individuals can change plans and also qualify for a subsidy. An application for Reduced Premium, Deductible, and Drug Out-of-Pocket Maximum must be submitted to qualify for a subsidy. Please see the "Plan Options Table" for more information on how the different subsidies apply to each HIRSP plan.

INSTRUCTIONS

Once each calendar year, members may request a change between plans. The requested change will be effective January 1 of the next calendar year if the member notifies HIRSP before November 1 of the current calendar year.

This means you should review the enclosed rate tables to determine the best plan for you in 2012. Please consider whether you want to change between HIRSP 1,000 / HIRSP 2,500 / HIRSP 5,000 / HIRSP Health Savings Account 2,500 / HIRSP Health Savings Account 3,500.

If you decide to change your coverage, fill out this form and sign it. ***If you do not want to make a change, no action is required on your part.***

Return this form to HIRSP by November 1, 2011. You may mail it to HIRSP at 1751 W. Broadway, PO Box 8961, Madison, WI 53708-8961. Or, fax it to (608) 243-6136.

If you have questions, contact HIRSP Customer Service at (800) 828-4777 or (608) 221-4551.

INFORMATION NEEDED TO CHANGE COVERAGE

Effective January 1, 2012, please change my coverage to:

- | | |
|---|---|
| <input type="checkbox"/> HIRSP 1,000 (\$1,000 deductible) | <input type="checkbox"/> HIRSP 5,000 (\$5,000 deductible) |
| <input type="checkbox"/> HIRSP 2,500 (\$2,500 deductible) | <input type="checkbox"/> HIRSP Health Savings Account (HSA) 2,500 |
| | <input type="checkbox"/> HIRSP Health Savings Account (HSA) 3,500 |

Name — Member: _____

Street Address: _____ City: _____ State: _____ ZIP Code: _____

HIRSP Member Number: _____	Current Plan: <input type="checkbox"/> HIRSP 1,000	<input type="checkbox"/> HIRSP 5,000	<input type="checkbox"/> HIRSP HSA 3,500
	<input type="checkbox"/> HIRSP 2,500	<input type="checkbox"/> HIRSP HSA 2,500	

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SIGNATURE — Requestor

Date Signed