Employee Enrollment / Change Form

☐ Initial Group ☐ COBRA ☐ Open Enrollment

☐ New Employee ☐ Change (complete change section on reverse side)

Benefits Administered by:
UMR - ENROLLMENT SERVICES
PO BOX 8052 - WAUSAU, WI 54402-8052

EMPLOYER NAME	GROUP NUMBER	EMPLOYEE START DATE
ATHENS COUNTY SCHOOLS CONSORTIUM	**76-411318**	
EMPLOYEE LOCATION:		HOURS WORKED WEEKLY

SOCIAL SECURITY NUMBER - -			ALTERNATE IDENTIFICATION NUMBER
NAME: LAST	FIRST		M.I.
ADDRESS	CITY	STATE ZIP	EMAIL ADDRESS
DATE OF BIRTH / /	GENDER ☐ M ☐ F	MARITAL STATUS	HOME TELEPHONE NUMBER ( )

Do you or any family member currently have other health coverage? ☐ Yes, single ☐ Yes, family ☐ No
If yes to the above question, complete the following:

Person's name _____ Employer Name _____

Carrier Name _____ Plan Number _____

Medical Plan (select one):

☐ **Option 2: PPO Plan 2**
☐ **Option 3: PPO Plan 3**
☐ **Option 4: HDHP Plan 4**

Coverage level (select one): ☐ **Employee** ☐ **Family** ☐ **Waive**

COMPLETE THIS SECTION IF ELECTING DEPENDENT COVERAGE

LAST FIRST MI	SS#	BIRTH DATE	GENDER	RELATIONSHIP TO EMPLOYEE
Spouse Name			☐ M ☐ F	
Child(ren) Name 1.			☐ M ☐ F	
2.			☐ M ☐ F	
3.			☐ M ☐ F	
4.			☐ M ☐ F	
5.			☐ M ☐ F	

COMPLETE THIS SECTION IF MAKING CHANGES.

Effective date of change: _____ **Please specify change and update in appropriate section.**

- ☐ Employee name change
- ☐ Employee address change
- ☐ Job location change
- ☐ Return to work
- ☐ Other coverage change
- ☐ Date of Marriage_____
- ☐ Date of Divorce_____
- ☐ Other _____
- ☐ Eligible for Medicaid/CHIP subsidy
- ☐ Loss of Eligibility for Medicaid/CHIP subsidy
- ☐ Add dependents
- ☐ Remove dependents (list names) _____ Reason: _____
- ☐ Add coverage
- ☐ Voluntarily Terminate coverage (Indicate which coverage)_____
- ☐ State/Federal Continuation

Employee Signature Required _____

- ☐ Employment termination:

Reason:_____ Last day worked_____Date coverage terminated_____

WAIVING COVERAGE

Important: If you decline benefits for yourself or your dependents, you may in the future be able to enroll yourself or your dependents in this benefit plan. You may have an opportunity to enroll during your annual enrollment period or if your family status changes. If you decline benefits because of other group health or insurance coverage, and state so in writing, you may have the opportunity to enroll under HIPAA Special Enrollment because of loss of that coverage. By checking the box below, you are attesting that you are declining enrollment in this plan because you are enrolled in other group health coverage:

☐ I attest that I am declining group health coverage because I am currently enrolled in other group health or insurance coverage. For specific plan language contact your Human Resources Representative.

CERTIFICATION: I freely and voluntarily waive all coverage noted above.

_____

EMPLOYEE SIGNATURE DATE

I hereby certify that all of the above information is true and correct. I understand that coverage will not be effective until all questions regarding eligibility for coverage have been satisfactorily resolved.

I understand that I may not change the coverage elections that I make on the Employee Enrollment/Change Form until the plan's next open/annual enrollment period or unless otherwise permitted by the Plan.

Please refer to your Employee Benefit Booklet for specific detail of your benefit plan.

☐ I hereby apply for coverage and authorize deductions from my earnings for the amount required, if any, to cover any contribution for coverage.

_____

EMPLOYEE SIGNATURE DATE