



Employee Enrollment / Change Form

- Initial Group COBRA Open Enrollment
- New Employee Change (complete change section on reverse side)

ENROLLMENT SERVICES
 PO BOX 8052
 WAUSAU, WI 54402-8052

EMPLOYER NAME Athens County Schools Consortium	GROUP NUMBER 76-411318	EMPLOYEE START DATE	EFFECTIVE DATE
---	---	----------------------------	-----------------------

LOCATION (select one)

- 002 - Alexander Local School District – Certified 6091 Ayers Road. Albany, OH 45710
- 003 - Alexander Local School District – Classified 6091 Ayers Road. Albany, OH 45710
- 004 - Alexander Local School District -COBRA 6091 Ayers Road, Albany, OH 45710
- 005 - Athens – Meigs Educational Service Center - Active 39105 Bradbury Rd., Middleport, OH 45760
- 006 - Athens – Meigs Educational Service Center - COBRA 39105 Bradbury Rd., Middleport, OH 45760
- 007 - Federal Hocking Schools - Certified, 8461 State Route 144, Box 117, Stewart, OH 45778
- 008 - Federal Hocking Schools - Non certified 8461 State Route 144, Box 117, Stewart, OH 45778
- 009 - Federal Hocking Schools - Administrative 8461 State Route 144, Box 117, Stewart, OH 45778
- 010 - Federal Hocking Schools - COBRA 8461 State Route 144, Box 117, Stewart, OH 45778
- 011 - Nelsonville – York City Schools, Two Buckyeye Dr., Nelsonville, OH 45764
- 012 - Nelsonville – York City Schools – COBRA Two Buckyeye Dr., Nelsonville, OH 45764
- 013 - Tri-County Career Center – Certified, 15676 State Route 691, Nelsonville, OH 45764
- 014 - Tri-County Career Center – Classified 15676 State Route 691, Nelsonville, OH 45764
- 015 - Tri-County Career Center – Non-Union 15676 State Route 691, Nelsonville, OH 45764
- 016 - Tri County Career Center – COBRA 15676 State Route 691, Nelsonville, OH 45764
- 017 - Trimble Local School District, One Tomcat Drive, Glouster, OH 45732
- 018 - Trimble Local School District - COBRA One Tomcat Drive, Glouster, OH 45732

SOCIAL SECURITY NUMBER - - -	ALTERNATE IDENTIFICATION NUMBER
--	--

NAME: LAST	FIRST	M.I.
------------	-------	------

ADDRESS	CITY	STATE	ZIP	EMAIL ADDRESS
---------	------	-------	-----	---------------

DATE OF BIRTH / /	GENDER	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 Coverage

- Plan 1
- Plan 2
- Plan 3
- Plan 4

Medical Tier Option

- Employee only
- Family
- Waive

Dental Plan Coverage

- Dental Plan

Dental Tier Option

- Employee only
- Family
- Waive

Dependent Coverage

Last Spouse Name	First	MI	SS#	Birth Date	Gender	
_____	_____	_____	_____	_____	_____	
Child Name			SS#	Birth Date	Gender	Relationship to Employee
1 _____			_____	_____	_____	_____
2 _____			_____	_____	_____	_____
3 _____			_____	_____	_____	_____
4 _____			_____	_____	_____	_____
5 _____			_____	_____	_____	_____

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
- Job title 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 coverages) _____
- 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