



Greenbush Health Captive – UMR Enrollment Form

- ☐ New Employee
☐ Change (complete change section)
☐ Open Enrollment

Benefits Administered by:
UMR Enrollment Service Department
PO Box 8052 Wausau, WI 54402-8052

EMPLOYER NAME (DISTRICT NAME)	UMR GROUP NUMBER	HIRE DATE	EFFECTIVE DATE
UMR EMPLOYEE LOCATION (3-digit location from UMR account structure)			

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

OTHER HEALTH INSURANCE INFORMATION

Do you or covered dependent(s) 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 _____

UMR PLAN AND TIER ELECTIONS

Medical Plan ☐ Option 1 PPO ☐ Option 2 PPO ☐ Option 3 PPO ☐ Option 4 QHDHP	Coverage Tier Level ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Family
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LAST	FIRST	MI	SS#	BIRTH DATE	GENDER	RELATIONSHIP TO EMPLOYEE
Spouse Name					☐ M ☐ F	
Child(ren) Name					☐ M ☐ F	
1.					☐ M ☐ F	
2.					☐ M ☐ F	
3.					☐ M ☐ F	
4.					☐ M ☐ F	
5.					☐ M ☐ F	

UMR CHANGE SECTION

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

- ☐ Employee name change
- ☐ Employee address change
- ☐ Job location change
- ☐ Job title change
- ☐ Earnings 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 (Please provide the information below)

Reason: _____ Last day worked _____ Date coverage terminated _____

UMR 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 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 details 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