

Employee Enrollment / Change Form



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

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

EMPLOYER NAME City of Mishawaka		GROUP NUMBER 76-411566	EMPLOYEE JOB LOCATION	
EMPLOYEE START DATE	EFFECTIVE DATE OF COVERAGE	HOURS WORKED WEEKLY	JOB TITLE/CLASS	

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 _____

<input type="checkbox"/> Medical <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Child(ren) <input type="checkbox"/> Family	<input type="checkbox"/> Dental <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Child(ren) <input type="checkbox"/> Family	<input type="checkbox"/> Vision <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Child(ren) <input type="checkbox"/> Family
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IF YOU ARE ELECTING OR CHANGING ANY OF THE ABOVE COVERAGES, PLEASE COMPLETE THE REMAINING SECTIONS OF THIS FORM ON THE REVERSE SIDE.

COMPLETE THIS SECTION IF ELECTING DEPENDENT COVERAGE

Name: (Last, First, I)	Social Security #	Date of Birth	Gender	Relationship
			M or F	Spouse
			M or F	
			M or F	
			M or F	
			M or F	
			M or F	
			M or F	

This plan allows dependents to age 26 to participate in the health plan.

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
 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 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