



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 ATHENS COUNTY SCHOOLS CONSORTIUM	GROUP NUMBER 76-411318	EMPLOYEE START DATE
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 <input type="checkbox"/> M <input type="checkbox"/> 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					<input type="checkbox"/> M <input type="checkbox"/> F	
Child(ren) Name					<input type="checkbox"/> M <input type="checkbox"/> F	
1.					<input type="checkbox"/> M <input type="checkbox"/> F	
2.					<input type="checkbox"/> M <input type="checkbox"/> F	
3.					<input type="checkbox"/> M <input type="checkbox"/> F	
4.					<input type="checkbox"/> M <input type="checkbox"/> F	
5.					<input type="checkbox"/> M <input type="checkbox"/> 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