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	EFFECTIVE DATE

EMPLOYEE JOB LOCATION

☐ Commonwealth Orthopaedic Centers
☐ Administration
☐ Chancellor
☐ Southgate
☐ Florence Turfway
☐ Florence Gunpowder Rd
☐ Edgewood Physical Therapy
☐ Southgate Physical Therapy
☐ DME
☐ MRI
☐ Physicians
☐ Physician Assistants
☐ Nurse Practitioners

SOCIAL SECURITY NUMBER

NAME: LAST FIRST M.I.

ADDRESS CITY STATE ZIP EMAIL ADDRESS

DATE OF BIRTH	GENDER ☐ M ☐ F	MARITAL STATUS	HOME TELEPHONE NUMBER

This Health Plan has a Pre-existing illness provision for 12 months or 12 months for a Late Enrollee. Proof of Creditable Health Coverage may reduce this time period.
This plan's pre-existing condition limitation does not apply in the case of members who have not yet attained the age of 19.

Have you attached a Certificate of Creditable Health Coverage for You and/or all Dependents? ☐ YES ☐ NO
If NO, contact your prior plan/employer or insurer to obtain a copy. If necessary, we will assist you. If a certificate is not available, other forms of proof may be submitted.

If Prior / Other Medical Coverage Has Been Entered It Will Appear on the Following Page(s)

Medical Plan

☐ **Consumer Advantage Plan** ☐ **HDHP with HSA Plan**

☐ Employee ☐ Employee plus spouse ☐ Employee plus child/children ☐ Family ☐ Waive

COMPLETE THIS SECTION IF ELECTING DEPENDENT COVERAGE

Last First MI Spouse Name	SS#	BIRTH DATE	GENDER	Relationship to Employee
_____	___ ___ _____	___ ___ _____	☐ M ☐ F	
Child Name	SS#			
1_____	___ ___ _____	___ ___ ___	☐ M ☐ F	_____
2_____	___ ___ _____	___ ___ ___	☐ M ☐ F	_____
3_____	___ ___ _____	___ ___ ___	☐ M ☐ F	_____
4_____	___ ___ _____	___ ___ ___	☐ M ☐ F	_____
5_____	___ ___ _____	___ ___ ___	☐ M ☐ F	_____

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

Employee Name: _____ SSN: _____

NAME	SOC. SEC #	DATE OF BIRTH	Gender	RELATIONSHIP
			☐ M ☐ F	
			☐ M ☐ F	
			☐ M ☐ F	
			☐ M ☐ F	
			☐ M ☐ F	
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IF YOU ARE ELECTING OR CHANGING ANY OF THE ABOVE COVERAGES, PLEASE COMPLETE THE REMAINING SECTIONS OF THIS FORM.

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:

If Waiving Coverage, Information Will Appear on the Following Page(s)

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