Employee Enrollment / Change Form

☐ Initial Group ☐ COBRA ☐ Open Enrollment

☐ New Employee ☐ Change (Complete change section on reverse side)

Benefits Administered by:
UMR - Enrollment Services
P.O. Box 8052
Wausau, WI 54402-8052

UMR

EMPLOYER NAME	GROUP NUMBER
Tri-County Educational Service Center	**76-411261**
Employee Start Date	Effective Date

Social Security Number		Email Address	
Last Name	First Name		M.I.
Address	City	State	Zip
Date of Birth / /	Gender ☐ M ☐ 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 _____

Do you or any family member currently have other dental coverage? ☐ Yes, single ☐ Yes, family ☐ No
If yes to the above question, complete the following: Person's Name _____
Employer Name _____ Carrier Name _____ Plan Number _____

Coverage Selection/Waiver

☐ **Medical Plan**	☐ Employee	☐ Family	☐ Waive
☐ **Dental Plan**	☐ Employee	☐ Family	☐ Waive
☐ **Life Insurance**	☐ Employee		☐ Waive

Complete this section if electing dependent coverage

	Last	First	MI	SS#	Birthdate	Gender	Relationship to Employee
Spouse Name				- -	/ /	☐ M ☐ F	
Child Name							
1				- -	/ /	☐ M ☐ F	
2				- -	/ /	☐ M ☐ F	
3				- -	/ /	☐ M ☐ F	
4				- -	/ /	☐ M ☐ F	
5				- -	/ /	☐ M ☐ F	

This plan excludes dependents age 19-26 if the dependent has access to employment-based coverage i.e., from their employer or their spouse's employer.

Life Insurance Beneficiary Information

	Last	First	MI	SS#	Birthdate	Gender	Relationship to Employee
1				- -	/ /	☐ M ☐ F	
2				- -	/ /	☐ M ☐ F	
3				- -	/ /	☐ M ☐ F	
4				- -	/ /	☐ M ☐ F	
5				- -	/ /	☐ M ☐ F	

If you are electing or changing any of the above coverages, please complete the remaining sections of this form.

Please specify change and update in appropriate section.

Effective date of change: _____

- ☐ 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 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