Employee Enrollment / Change Form

Benefits Administered by

UMR

ENROLLMENT SERVICES
PO BOX 8052 • WAUSAU WI 54402-8052

☐ Initial Group ☐ COBRA ☐ Open Enrollment

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

Employer

EMPLOYER NAME	GROUP NUMBER	EMPLOYEE JOB LOCATION
ROMAN CATHOLIC DIOCESE OF LEXINGTON	76530007	

EMPLOYEE START DATE	EARNINGS	HOURS WORKED WEEKLY	JOB TITLE

Employee

SOCIAL SECURITY NUMBER - -

ALTERNATE IDENTIFICATION NUMBER

NAME: LAST FIRST M.I.

ADDRESS CITY STATE ZIP E-MAIL ADDRESS

DATE OF BIRTH / /	SEX	MARITAL STATUS	HOME TELEPHONE NUMBER ( )

Portability

This Health Plan has a Pre-existing illness provision for 12 months or 18 months. Proof of Creditable Health Coverage may reduce this time period.

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.

Other Health Coverage

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 _____

Other Dental Coverage

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 _____

Coverages

• Health Coverage:

☐ **Medical Plan**

Class # _____

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

☐ Waive

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

Dependents

Last First MI Spouse Name	SS#	BIRTH DATE	GENDER	Relationship to Employee	Does child reside with you?	Do you claim this dependent as an exemption for Federal Incometax purposes?	Do you provide more than 50% Support?
	- -	/ /					
Child Name							
1	- -	/ /					
2	- -	/ /					
3	- -	/ /					
4	- -	/ /					
5	- -	/ /					

Indicate any dependent children listed above who are 19 or older and are full-time students. Please comlpete the questions below for student status.

1. Is the dependent child a full-time student? _____
2. How many credits and what semester is dependent child registered for? _____
3. What is the actual or anticipated graduation date? _____
4. What is the school name? _____

COMPLETE THIS SECTION IF MAKING CHANGES.

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 ☐ Beneficiary change ☐ Other coverage change ☐ Date of marriage _____
- ☐ Other _____ ☐ Date of divorce _____
- ☐ 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

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