



Employee Enrollment / Change Form

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

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

EMPLOYER NAME Village of Germantown	GROUP NUMBER 76415240	EMPLOYEE START DATE	EFFECTIVE DATE
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LOCATION
 Village of Germantown (001)

SOCIAL SECURITY NUMBER	ALTERNATE IDENTIFICATION NUMBER
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LAST NAME	FIRST NAME	Middle Initial
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STREET ADDRESS	CITY	STATE	ZIP CODE	EMAIL ADDRESS
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DATE OF BIRTH (mm/dd/yy)	GENDER <input type="checkbox"/> M <input type="checkbox"/> F	MARITAL STATUS	HOME TELEPHONE NUMBER (Area Code + Number)
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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 _____

(Select One Medical Plan)

<input type="checkbox"/> Gold Plan <input type="checkbox"/> Employee <input type="checkbox"/> Employee plus spouse <input type="checkbox"/> Employee plus child(ren) <input type="checkbox"/> Family <input type="checkbox"/> Waive	<input type="checkbox"/> Silver Plan <input type="checkbox"/> Employee <input type="checkbox"/> Employee plus spouse <input type="checkbox"/> Employee plus child(ren) <input type="checkbox"/> Family <input type="checkbox"/> Waive
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COMPLETE THIS SECTION IF ELECTING DEPENDENT COVERAGE

LAST	FIRST	MI	SS#	BIRTH DATE	GENDER	RELATIONSHIP TO EMPLOYEE
Spouse Name			Spouse SSN	Spouse DOB	<input type="checkbox"/> M <input type="checkbox"/> F	
Dependent 1 Name 1.			Dependent 1 SSN	Dependent 1 DOB	<input type="checkbox"/> M <input type="checkbox"/> F	Dependent 1 Relationship to EE
Dependent 2 Name 2.			Dependent 2 SSN	Dependent 2 DOB	<input type="checkbox"/> M <input type="checkbox"/> F	Dependent 1 Relationship to EE
Dependent 3 Name 3.			Dependent 3 SSN	Dependent 3 DOB	<input type="checkbox"/> M <input type="checkbox"/> F	Dependent 1 Relationship to EE
Dependent 4 Name 4.			Dependent 4 SSN	Dependent 4 DOB	<input type="checkbox"/> M <input type="checkbox"/> F	Dependent 1 Relationship to EE
Dependent 5 Name 5.			Dependent 5 SSN	Dependent 5 DOB	<input type="checkbox"/> M <input type="checkbox"/> F	Dependent 1 Relationship to EE

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
 - 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