Employee Enrollment / Change Form

☐ Initial Group ☐ COBRA ☐ Open Enrollment

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

ENROLLMENT SERVICES
PO BOX 8052
WAUSAU, WI 54402-8052

EMPLOYER NAME	GROUP NUMBER	EMPLOYEE START DATE	EFFECTIVE DATE
The School District of North Fond du Lac	**76416660**		

LOCATION	JOB TITLE

SOCIAL SECURITY NUMBER	ALTERNATE IDENTIFICATION NUMBER
- -	

NAME: LAST FIRST M.I.

ADDRESS CITY STATE ZIP EMAIL ADDRESS

DATE OF BIRTH	GENDER	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 Coverage and Tier Options

☐ Employee only
☐ Family

☐ Waive

Last First MI Spouse Name	SS#	Birth Date	Gender	
_____	_____	_____	_____	
Child Name	**SS#**	**Birth Date**	**Gender**	**Relationship to Employee**
1_____	_____	_____	_____	_____
2_____	_____	_____	_____	_____
3_____	_____	_____	_____	_____
4_____	_____	_____	_____	_____
5_____	_____	_____	_____	_____

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