Employee Enrollment / Change Form

☐ New Employee ☐ Change in coverage

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

SOCIAL SECURITY NUMBER - -			
NAME: LAST	FIRST		M.I.
ADDRESS	CITY	STATE	ZIP
DATE OF BIRTH / /	GENDER ☐M ☐F	MARITAL STATUS	TELEPHONE NUMBER ( )

Coverage level: ☐ Employee Only ☐ Employee + One ☐ Family *must provide documentation for eligible dependents

COMPLETE THIS SECTION IF ELECTING DEPENDENT COVERAGE

Last First MI	SS#	BIRTH DATE	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 allows all dependents under age 26 to participate in the health plan.

COMPLETE THIS SECTION IF MAKING CHANGES.

Effective date of change:__________________ **Please specify change and update in appropriate section.**

- ☐ Birth/Adoption
- ☐ Marriage
- ☐ Divorce
- ☐ Changes in other coverage
- ☐ Other ________________________

COVERAGE ELECTION

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