Employee Enrollment / Change Form

☐ Initial Group ☐ COBRA ☐ Open Enrollment

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

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

EMPLOYER NAME	GROUP NUMBER	EMPLOYEE JOB LOCATION	
MANATTS, INC.	**76-411571**		
EMPLOYEE START DATE	EFFECTIVE DATE OF COVERAGE	HOURS WORKED WEEKLY	JOB TITLE

SOCIAL SECURITY NUMBER - -			ALTERNATE IDENTIFICATION NUMBER	
NAME: LAST		FIRST		M.I.
ADDRESS	CITY	STATE	ZIP	EMAIL ADDRESS
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_____

☐ **Medical Plan**

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

☐ Waive

COMPLETE THIS SECTION IF ELECTING DEPENDENT COVERAGE

Last First MI	SS#	BIRTH DATE	GENDER	
Spouse Name				
_____	___-___-___	___/___/___	☐ M ☐ F	
Child Name				Relationship to Employee
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.

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 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