

Employee Enrollmen	t / Change Fo	rm				*
☐ Initial Group	\square COBRA	Open Enrollm	ent	Benefits	Administered	by:
•		•			ENROLLMENT S	
☐ New Employee	Change (cor	nplete change section			8052 WAUSAU,	
New Employee		reverse side)		ТОВОХ	bosz wadsad,	W1 34402-8032
ELEN OLIED MALE	OII	,		E) (D) () ()		TION.
EMPLOYER NAME		GROUP NUMBER		EMPLOYI	EE JOB LOCA	TION
MANATTS, INC.	_	76-411571				
EMPLOYEE START DATE	EFFECTIVE D.	ATE OF COVERAGE	HOURS V	VORKED	JOB TITLE	
			WEEKLY	7		
	•	ſ	1			
SOCIAL SECURITY NUMBER			ALTERNATE	IDENTIFICA	ATION NUMBE	R
NAME: LAST		FIRST			M.I.	
ADDRESS	CI	ГҮ	STATE	ZIP		EMAIL ADDRESS
DATE OF BIRTH	GENDER	MARITAL STATUS		HOME TEL	EPHONE NUM	RFR
/ /		WI HOLL BITTLES		()	EI HOIVE IVOIVI	BER
, ,						
Do you or any family member	currently have oth	er health coverage?	Yes, sir	ngle 🔲 🗅	Yes, family	☐ No
If yes to the above question, co	omplete the following	ng: Person's name				
Employer Name	•	Carrier Name			Plan Numl	per
1 3						
☐ Medical Plan						
☐ Medical Plan						
_						
 ☐ Employee						
☐ Employee ☐ Employee plus spouse						
☐ Employee ☐ Employee plus spouse ☐ Employee plus child/child	ren					
☐ Employee ☐ Employee plus spouse	ren					
☐ Employee ☐ Employee plus spouse ☐ Employee plus child/child ☐ Family	ren					
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☐ Employee ☐ Employee plus spouse ☐ Employee plus child/childı ☐ Family ☐ Waive		BIRTH GENDE				
Employee Employee plus spouse Employee plus child/childs Family Waive COMPLETE THIS SECTION I Last First MI	F ELECTING DEI					
☐ Employee ☐ Employee plus spouse ☐ Employee plus child/childs ☐ Family ☐ Waive COMPLETE THIS SECTION I	F ELECTING DEI	BIRTH GENDE DATE	R			
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I his 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.

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 Divorce	_
Other		
	y Loss of Eligibility for Medicaid/CHIP so	ubsidy
Add dependents	_	
- · · · · · · · · · · · · · · · · · · ·	Reason:	
Add coverage	T 0	
	ndicate which coverages) St	ate/Federal Continuation
Employ Employment termination: Reason:	yee Signature Required Last day worked	Date coverage terminated
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 fu	ture be able to enroll yourself or your dependents in
this benefit plan. You may have an op	pportunity to enroll during your annual enrollm	ent period or if your family status changes. If you
this benefit plan. You may have an of decline benefits because of other gr	pportunity to enroll during your annual enrollm oup health or insurance coverage, and state so it	ent period or if your family status changes. If you n writing, you may have the opportunity to enroll
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EMPLOYEE SIGNATURE