



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 Jefferson Local Schools	GROUP NUMBER 76-415465	EMPLOYEE START DATE	EFFECTIVE DATE
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LOCATION (Select one)

SOCIAL SECURITY NUMBER - -	ALTERNATE IDENTIFICATION NUMBER
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NAME: LAST FIRST M.I.

ADDRESS CITY STATE ZIP EMAIL ADDRESS

DATE OF BIRTH / /	GENDER	MARITAL STATUS	HOME TELEPHONE 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 _____

Do you or any family member currently have other dental coverage? Yes, single Yes, family No

If yes to the above question, complete the following: Person's name _____

Employer Name _____ Carrier Name _____ Plan Number _____

<p>Medical Plan Coverage and Tier Options</p> <p> <input type="checkbox"/> Administrative Employees <input type="checkbox"/> Classified Employees <input type="checkbox"/> Certified Employees <input type="checkbox"/> Bronze Administrative Employees <input type="checkbox"/> Bronze Classified Employees <input type="checkbox"/> Bronze Certified Employees <input type="checkbox"/> Employee only <input type="checkbox"/> Family <input type="checkbox"/> Waive </p>	<p>Dental Plan Coverage and Tier Options</p> <p> <input type="checkbox"/> Employee only <input type="checkbox"/> Family <input type="checkbox"/> Waive </p>
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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