Medical

UMR

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
HAND SURGERY ASSOCIATES OF INDIANA INC	76-411362	001

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	MARITAL STATUS	HOME TELEPHONE NUMBER
/ /	☐ M ☐ F		( )

This Health Plan has a Pre-existing illness provision for 12 months or 18 months for a Late Enrollee. Proof of Creditable Health Coverage may reduce this time period.
This plan's pre-existing condition limitation does not apply in the case of members who have not yet attained the age of 19.
Have you attached a Certificate of Creditable Health Coverage for You and/or all Dependents? ☐ YES ☐ NO
If NO, contact your prior plan/employer or insurer to obtain a copy. If necessary, we will assist you. If a certificate is not available, other forms of proof may be submitted.

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 for Partners, Employed Physicians & Fellows**
☐ **Medical Plan for All other employees**

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

☐ Waive

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 excludes dependents age 19-26 if the dependent has access to employment-based coverage (i.e. from their employer or their spouse's employer)

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 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