



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 City of Hoboken	GROUP NUMBER 76-412486	EMPLOYEE LOCATION for Office use only (*Required)
EMPLOYEE START DATE		EFFECTIVE DATE

SOCIAL SECURITY NUMBER			
NAME: LAST	FIRST	M.I.	
ADDRESS	CITY	STATE	ZIP EMAIL ADDRESS
DATE OF BIRTH / /	GENDER <input type="checkbox"/> M <input type="checkbox"/> F	MARITAL STATUS	HOME TELEPHONE NUMBER ()
Do you or any family member currently have other health coverage? <input type="checkbox"/> Yes, single <input type="checkbox"/> Yes, family <input type="checkbox"/> 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	Relationship to Employee
Spouse Name						
_____	_____	_____	____-____-____	____/____/____	<input type="checkbox"/> M <input type="checkbox"/> F	_____
Child Name						
1	_____	_____	____-____-____	____/____/____	<input type="checkbox"/> M <input type="checkbox"/> F	_____
2	_____	_____	____-____-____	____/____/____	<input type="checkbox"/> M <input type="checkbox"/> F	_____
3	_____	_____	____-____-____	____/____/____	<input type="checkbox"/> M <input type="checkbox"/> F	_____
4	_____	_____	____-____-____	____/____/____	<input type="checkbox"/> M <input type="checkbox"/> F	_____
5	_____	_____	____-____-____	____/____/____	<input type="checkbox"/> M <input type="checkbox"/> 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.

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
- Earnings 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
- 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 details 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