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 START DATE	EFFECTIVE DATE
Northland College	**76414062**		

LOCATION
☒ Northland College (001)

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** ☐ Waive

☐ Gold
☐ Silver
☐ Bronze
☐ Post 65 – Medicare Supplement

☐ Employee
☐ Employee plus one
☐ Family
☐ Employee plus domestic partner

☐ UHC Choice Plus PPO

☐ **Vision Plan** ☐ Waive

☐ Employee
☐ Employee plus one
☐ Family
☐ Employee plus domestic partner

COMPLETE THIS SECTION IF ELECTING DEPENDENT COVERAGE

LAST FIRST MI	SS#	BIRTH DATE	GENDER	RELATIONSHIP TO EMPLOYEE
1.			☐ M ☐ F	
2.			☐ M ☐ F	
3.			☐ M ☐ F	
4.			☐ M ☐ F	
5.			☐ M ☐ F	
6.			☐ M ☐ F	

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

ENROLLMENT/CHANGE/WAIVER FORM - Dental

PLEASE NOTE THAT COMPLETING THIS FORM DOES NOT GUARANTEE COVERAGE.

DELTA DENTAL®

EMPLOYER USE ONLY

GROUP NUMBER _____ _____ _____ _____ EFFECTIVE DATE _____

COMPLETE THIS SECTION IF YOU ARE ACCEPTING, CHANGING OR TERMINATING COVERAGE

EMPLOYEE'S LAST NAME	FIRST	M.I.	SSN OR EMPLOYER-ASSIGNED ID	DATE OF BIRTH MO DAY YR	SEX
			— —	/ /	❑ F ❑ M

HOME ADDRESS - STREET	CITY	STATE	ZIP

PLAN NAME	COLLEGE/UNIVERSITY NAME	DATE OF HIRE MO DAY YR
WAICU Benefits Consortium		/ /

LIST ALL ELIGIBLE FAMILY MEMBERS TO BE COVERED LAST NAME (IF DIFFERENT)	FIRST	M.I.	RELATIONSHIP SON	 DAU.	DATE OF BIRTH MO	 DAY	 YR
SPOUSE / DOMESTIC PARTNER							

Choose Plan: ❑ Gold ❑ Silver ❑ Bronze

REASON FOR SUBMITTING THIS FORM
❑ NEW ENROLLEE ❑ REHIRE (Date: _____)

IF THIS IS FOR CHANGE, WHAT IS THE REASON?

	DATE OCCURRED
❑ BIRTH/ADOPTION (Name: _____)	_____
❑ MARRIAGE/ ❑ DIVORCE	_____
❑ ADD/ ❑ DROP DEPENDENT (Name: _____)	_____
❑ TERMINATION OF BENEFITS (Reason: _____)	_____
❑ LOSS OF DENTAL BENEFITS	_____
❑ NAME CHANGE (Former Name: _____)	_____
❑ ADDRESS CHANGE _____	
❑ GROUP TRANSFER (From _____ to _____)	_____
❑ COBRA APPLICATION	_____

WHAT TYPE OF COVERAGE ARE YOU APPLYING FOR?
❑ EMPLOYEE ONLY ❑ EMPLOYEE & SPOUSE / DOMESTIC PARTNER
❑ EMPLOYEE & CHILD(REN) ❑ EMPLOYEE & FAMILY

YOUR MARITAL STATUS ❑ SINGLE ❑ MARRIED

IF YOU ARE NOT ACCEPTING COVERAGE FOR YOUR SPOUSE OR DEPENDENTS, ARE THEY COVERED BY ANOTHER DENTAL PLAN? ❑ YES ❑ NO

❑ **Accept Coverage**

X _____ _____
SIGNATURE IS REQUIRED DATE

COMPLETE THIS SECTION **ONLY** IF YOU ARE **WAIVING** COVERAGE

EMPLOYEE'S LAST NAME	FIRST	M.I.	SSN OR EMPLOYER-ASSIGNED ID
			— —

EMPLOYER NAME AND LOCATION

PLEASE CHECK ONE:
❑ I HAVE COVERAGE THROUGH MY SPOUSE
❑ I HAVE OTHER DENTAL COVERAGE
❑ I DO NOT HAVE OTHER DENTAL COVERAGE

❑ **Waive Coverage**

X _____ _____
SIGNATURE IS REQUIRED DATE

Acceptance of Coverage
I accept the insurance provided by my employer's group insurance plan. I authorize deductions from my earnings for the required contributions toward the cost of insurance. (This authorization applies only if employee contributions are required.) I understand that by accepting insurance, I am required to remain enrolled as a covered employee and cannot make an elective change in the coverage selected until the next open enrollment period, if there is one provided for in the Master Agreement to Provide Dental Benefits.

Waiver of Coverage
I understand that if I decide not to apply for coverage, or if I apply only for single coverage even though I am eligible for family coverage, any subsequent application will be subject to the applicable terms and conditions of the Master Agreement to Provide Dental Benefits, which may require additional limitations and waiting periods. I also understand that Delta Dental of Wisconsin, Inc. reserves the right to reject such an application.

NORTHLAND COLLEGE

IRS 125 Flexible Spending Account
Annual Enrollment Form

Calendar Year 2021

(Coverage election must be made <u>within 10 days</u> of hire date)

Employee Name: _____ ID:_____

( ) I elect <u>NOT TO PARTICIPATE</u> in any Healthcare Spending or Dependent Care spending accounts.

OR

Election of Healthcare Spending Account or Dependent Care Spending Account
(Minimum contribution is $120 annually.)

I elect to make optional pre-tax contributions to the following accounts:

( ) Healthcare Flexible Spending Account **$ _____ (annually)**

The annual plan limit that may be allocated to the health care reimbursement account is **$2,750**.

( ) Dependent Care Flexible Spending Account **$ _____(annually)**

The annual plan limit that may be allocated to the dependent care reimbursement account is **$5,000**.

Eligible and ineligible expenses and claim forms are found at https://member-fhs.umr.com/portal

Type of Reimbursement for Healthcare Flexible Spending Account

( ) **Manual Reimbursement**
-you fill out the claim form at your convenience and submit to UMR

( ) **Automatic Reimbursement** HR/EX: Header/UDef/B
-claims will automatically be processed, you will not have to manually submit a claim form

The auto reimbursement feature gives you the ability to have claims automatically reimbursed by the Healthcare Flexible Spending Account. This means that for those claims applied to the deductible or otherwise not covered by the medical plan, the claims will automatically roll to the Heathcare Flexible Spending Account for processing. You will not have to file a separate claim form.

****The automatic reimbursement feature is <u>not</u> an option for employees who coordinate benefits with other coverage, i.e. their spouse's coverage.**

Reimbursement
I elect to receive reimbursement from my spending account for the plan year by:

( ) Direct Deposit Account on file with payroll (Default election unless otherwise specified)

( ) Check (A check will be mailed to your home)

( ) **Savings Account** (attach deposit slip)

Note: If you choose to change your reimbursement method outside the open enrollment period <u>YOU</u> will be responsible to notify UMR.

Authorization
I authorize the required contribution for my Flexible Spending Account choices to be deducted from my paycheck on a pre-tax basis. I have reviewed my Flexible Spending Account choices and certify that they reflect my needs. I also understand that I will forfeit any funds remaining in either Flexible Spending Account 90 days after the plan year.

I also understand that the Flexible Spending Account elections indicated on this form will remain in effect until changed during a subsequent enrollment period, or there is a change in my family status allowing me to change my election.

I certify that the expenses for which I am requesting through my Flexible Spending Account are expenses incurred by me or my eligible dependents and have not been reimbursed in any other way or from any other source.

_____ _____
Employee's Signature Date

Failure to return this form by deadline will result in non-participation in pre-tax benefit options!!