

Employee Enrollment / Change Form Initial Group COBRA Open Enrollment Benefits Administered by: UMR - ENROLLMENT SERVICES New Employee Change (complete change section PO BOX 8052 WAUSAU, WI 54402-805

New Employee	Employee			PO BOX 8052 WAUSAU, WI 54402-8052			
EMPLOYER NAME Northland Col		ROUP NUMBER 76414062	EMPI	LOYEE START DA	TE	EFFECTIVE DATE	
LOCATION Northland College (001)			•				
SOCIAL SECURITY NUMBER		A	LTERN <i>A</i>	ATE IDENTIFICATIO	MUN NC	IBER	
NAME: LAST	FIRST		M.I.			M.I.	
ADDRESS	CITY	STATE		ZIP	EMAIL ADDRESS		
DATE OF BIRTH	GENDER MARITA	AL STATUS		HOME TELEPHONE NUMBER		BER	
Do you or any family member currently have other health coverage?							
☐ Medical Plan ☐ Waive							
☐ Gold ☐ Employee ☐ Employee ☐ UHC Choice Plus PPO ☐ Bronze ☐ Family ☐ Post 65 – Medicare Supplement ☐ Employee plus domestic partner							
☐ Employee ☐ Vision Plan ☐ Waive ☐ Employee plus one ☐ Family ☐ Employee plus domestic partner							
COMPLETE THIS SECTION IF ELECTING DEPENDENT COVERAGE							
LAST FIRST MI	SS#	BIRTH DAT	E	GENDER	REL	ATIONSHIP TO EMPLOYEE	

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	

COMPLETE THIS SECTION IF MAKING CHANG	ES.	
Effective date of change:	_ Please specify change and upo	late 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	7	
Loss of Eligibility for Medicaid/CH	IP subsidy	
Add dependents		
Remove dependents (list names) _	Reason:	
Add coverage		
☐ Voluntarily Terminate coverage (Ir	ndicate which coverages)	<u> </u>
State/Federal Continuation		
Employee Si	gnature Required	
Employment termination: Reason:	Last day worked_	Date coverage terminated
	WAIVING COVERA	AGE
dependents in this benefit plan. You status changes. If you decline bene have the opportunity to enroll under are attesting that you are declined.	may have an opportunity to enrol fits because of other group health HIPAA Special Enrollment because ning enrollment in this plan because	ou may in the future be able to enroll yourself or your l during your annual enrollment period or if your family or insurance coverage, and state so in writing, you may of loss of that coverage. By checking the box below, you go you are enrolled in other group health coverage:
		ur Human Resources Representative
CERTIFIC	ATION: I freely and voluntarily wa	aive all coverage noted above.
TIMP.	LOVER GLONATURE	DATE:
EMP	LOYEE SIGNATURE	DATE
		stand that coverage will not be effective until all
questions regarding eligibility for coverag	-	
		e Employee Enrollment/Change Form until the plan's
next open/annual enrollment period or u		
Please refer to your Employee Benefit Boo	-	•
I hereby apply for coverage and author contribution for coverage.	orize deductions from my earnings	for the amount required, if any, to cover any
EMPI	LOYEE SIGNATURE	DATE