

## SWEETWATER COUNTY<br/>SCHOOL DISTRICT #1Active Employee<br/>2023-2024 Enrollment Form

□ Open Enrollment □ New Full-Time Employee

Change (must also complete & sign top box on the second page)



Benefits Administered by: UMR - ENROLLMENT SERVICES PO BOX 8052 - WAUSAU, WI 54402-8052

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Position: EMPLOYEE LOCATION: EMPLOYEE STATUS: Active Employee Pre-65 Retiree Post 65 Retiree									
	SOCIAL SECU	JRITY NUMBER				ost 05 Kethee			
Social Security Numbe -	er: NAME:	- LAST			FIRST		M.I.		
Name: Last	ADDRESS		First	ТҮ	STATE	M.J. Zll <sup>j</sup> .	EMAIL AI	DRES	
Address:	DATE OF BIR		GENDER	MARITAL STA	ΓUS	HOME TELE ( )	EPHONE NUMBER		
Date of Birth / /	<b>Geneturor</b> and <b>Lifyres</b> to the a Person's name	/ famisomathemails bove question, comp	rently have oth blete the followi	er health covera ng:	seCell Numbers. Employer Na		es, family 🗌 No		
Will you or any depend							es, family 🗌 No		
Member name Carrier Name	Do you or any If yes to the a Person's name	y family member cur bove question, comp	rently have <b>5th</b> blete the followi Pla	pl <b>oyen Nama</b> ng: in Number	ge? Yes,	single Ye	es, family D No		
Will you or any dependenCanainNaincother DENTAL coverage in addition to UMR?       Plan Niethorsingle       Yes, family       No         Person's name									
Coverage level (select one):       Coverage level (select one):         Image: Imag									
Dental Plan: Elect Grandlathered PPO Plan Stand-alone Vision Plan Coverage level: Coverage level (select ane): Employee + Spouse Employee + Child / Children Waive Family									
					loyee + Child	<b>/Children</b> Family 🕒 Wa	<sub>aive</sub> Family		
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Effective date of change:	
Add or change coverage due to life event or family status change	
Add dependent(s)	
Date of Marriage	_
Date of Divorce	_
Voluntarily terminate/waive coverage(s): Plan type(s)	
Remove dependent(s): Name(s)	Reason:
Eligible for Medicaid/CHIP subsidy	
Loss of Eligibility for Medicaid/CHIP subsidy	
State/Federal Continuation	
Employee name change	
Other	
Employee Signature Required	
WAIVING COVERAGE	
<b>Important:</b> If you decline benefits for yourself or your dependent enroll yourself or your dependents in this benefit plan. You may have annual enrollment period or if your family status changes. If you de health or insurance coverage, and state so in writing, you may he HIPAA Special Enrollment due to loss of said coverage. By checking you are declining enrollment in this plan due to other group health or	ve an opportunity to enroll during the ecline benefits because of other group ave the opportunity to enroll under the box below, you are attesting that
☐ I attest that I am declining group health coverage because I am cu insurance coverage. For specific plan language, please review the ap the UMR member portal.	
<b>CERTIFICATION:</b> I freely and voluntarily waive all co	verage noted above.
SIGNATURE	DATE
I hereby certify the above information is true and correct. I understan questions regarding eligibility for coverage have been satisfactorily re	
I understand that I may not change coverage elections until the next an otherwise permitted by the SCSD1 Plan Document.	nnual open enrollment period unless
I understand it is my responsibility to ensure this form and all require Human Resources by the required deadline and to notify SCSD1 of con	

I hereby apply for coverage and agree to pay the approved employee premium contribution amount through payroll deductions or, if necessary, manual payment or ACH deduction.

Please maintain a copy of this form for your records.

For coverage inquiries, please refer to the SCSD1 UMR Plan Document available on the Member Portal at <u>www.umr.com</u>