SWEETWATER COUNTY SCHOOL DISTRICT #1

Active Employee 2023-2024 Enrollment Form

UMR

☐ **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

SWEETWATER COUNTY SCHOOL DISTRICT #1	GROUP NUMBER **76-520025**	Effective date: (office use only)
Position: Location:		

Social Security Number: - -

Name: Last First M.I.

Address:

Date of Birth / /	Gender ☐ M ☐ F	Personal Email:	Cell Number:

Will you or any dependent maintain other MEDICAL coverage in addition to UMR? ☐ Yes, single ☐ Yes, family ☐ No

Member name _____ Employer Name _____

Carrier Name_____ Plan Number_____

Will you or any dependent maintain other DENTAL coverage in addition to UMR? ☐ Yes, single ☐ Yes, family ☐ No

Person's name _____ Employer Name _____

Carrier Name_____ Plan Number_____

Medical Plan: ☐ **$1,000 PPO Plan** ☐ **$1,600 Qualified HDHP** ☐ **$2,500 Qualified HDHP** ☐ **Waive**

Coverage level: ☐ **Employee** ☐ **Employee + Spouse** ☐ **Employee + Child/Children** ☐ **Family**

Dental Plan: ☐ **Elect** ☐ **Waive**

Coverage level: ☐ **Employee** ☐ **Employee + Spouse** ☐ **Employee + Child/Children** ☐ **Family**

Vision Plan: ☐ **Elect** ☐ **Waive**

Coverage level: ☐ **Employee** ☐ **Employee + Spouse** ☐ **Employee + Child/Children** ☐ **Family**

COMPLETE THIS SECTION IF ELECTING DEPENDENT COVERAGE

LAST FIRST MI	SS#	BIRTH DATE	GENDER	RELATIONSHIP
			☐ M ☐ F	
			☐ M ☐ F	
			☐ M ☐ F	
			☐ M ☐ F	
			☐ M ☐ F	
			☐ M ☐ F	

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

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 the 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 due to loss of said coverage. By checking the box below, you are attesting that you are declining enrollment in this plan due to other group health coverage enrollment.

☐ I attest that I am declining group health coverage because I am currently enrolled in other health insurance coverage. For specific plan language, please review the applicable Plan Document available on the UMR member portal.

CERTIFICATION: I freely and voluntarily waive all coverage noted above.

_____

SIGNATURE DATE

I hereby certify the above information is true and correct. I understand coverage will not be effective until all questions regarding eligibility for coverage have been satisfactorily resolved.

I understand that I may not change coverage elections until the next annual open enrollment period unless otherwise permitted by the SCSD1 Plan Document.

I understand it is my responsibility to ensure this form and all required paperwork are submitted to SCSD1 Human Resources by the required deadline and to notify SCSD1 of contact information updates.

☐ 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.

_____

EMPLOYEE SIGNATURE DATE

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 www.umr.com