Group Plan
New Hire Enrollment & Change Form
Please Print

Employer Information

Employer: __CEDARBURG SCHOOL DISTRICT___ Group Number _____

❑ NEW ENROLLMENT ❑CHANGE Effective Date of Coverage _____ Date of Hire: _____

Employee Information

Last Name	First Name	M.I.	Sex	Date of Birth	ID No. or Social Security No.
			❑ Male ❑ Female		

Street Address	City	State	Zip Code	Cell or Home Phone

Marital Status: ❑ Single ❑ Married Date: _____ ❑ Divorced Date: _____ ❑ Widowed Date: _____

Coverage Type

I AM ENROLLLING IN THE FOLLOWING COVERAGES:

MEDICAL – *Choose One*
Plan HSA:
❑ Single
❑ Family

I hereby apply for coverage & authorize deductions from my earnings for the amount required, if any, to cover any contribution for coverage.

I AM WAIVING COVERAGE FOR:

MEDICAL
❑ Single
❑ Family

If waiving coverage, I understand that entrance in the plan may be limited if I choose to apply for such coverage at a later date.

I AM REQUESTING THE FOLLOWING CHANGES:

❑ DROP; Reason: ❑ Divorce; ❑ Voluntarily Drop ❑ Widowed
Address of dropped Spouse/dependent:
_____

❑ ADD; Reason: ❑ Spouse ❑Newborn ❑ Adoption
❑ Placed for Adoption ❑ Loss of other Coverage
❑ Other _____
❑ Date of Event _____

Dependent Information

Spouse's Last Name	First Name	M.I.	Sex	Spouse's Date of Birth
			❑ Male ❑ Female	

Spouse's Employer (Complete Name & Address)	Spouse's Social Security No.

DEPENDENT CHILDREN INFORMATION Last Name	First Name	M.I.	**Sex**	Date of Birth	Social Security No.	Relationship to Employee

Additional Information

1. Are you or any dependents covered under Medicare? ❑ Yes ❑ No: Person(s) Name(s) _____
   Medicare ID #(s) _____ Eff Date(s) _____
2. Do you or any dependents have any other MEDICAL coverage? ❑ Yes ❑ No, Covered Individuals? _____
   Policy No. _____ Company Name _____ Policy Holder _____

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 that I make unless there is a qualifying event or during open enrollment.

EMPLOYEE SIGNATURE: _____ **DATE:** _____

PLEASE RETURN THIS FORM TO YOUR EMPLOYER FOR APPROVAL AND PROCESSING.