Cedarburg School District

Challenging Students to Achieve Their Goals and Dreams

Insurance Application Information

Full-time employees (those who are scheduled to work at least 30 hours per week for the entire school year) are eligible for health and/or dental insurance. Applications for insurance benefits may be submitted by eligible employees:

1. upon being hired by the District;
2. during the annual open enrollment window (mid-November through early December);
3. within 30 days of a qualifying event (i.e., birth of a child, marriage, divorce, etc.).

Original completed application must be received by the payroll department in a timely manner.

Please direct questions to the Payroll/Benefits Office at extension 6113.

WCA Group Health Trust

Group Plan
New Hire Enrollment & Change Form
Please Print

UMR
A United-Healthcare Group Company

Employer Information

Employer: CEDARBURG SCHOOL DISTRICT Group Number 76-440143

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

Employee Information

Last Name	First Name	MI	Sex ☐ Male ☐ Female	Date of Birth	Social Security No. or ID#

Street Address	City	State	Zip Code	Home Phone

Marital Status: ☐ Single ☐ Married Date:_____ ☐ Legally Separated Date:_____ ☐ Divorced Date:_____ ☐ Widowed Date:_____

Coverage Type

I AM ENROLLING IN THE FOLLOWING COVERAGES:

MEDICAL
☐ 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; ☐ Legal Separation; ☐ Voluntarily Drop
Address of dropped spouse/dependent: _____

☐ Widowed; Date: _____

☐ **ADD; Reason:** ☐ Spouse, due to marriage ☐ Newborn ☐ Adoption ☐ Placed for Adoption ☐ Step Child ☐ Grandchild ☐ Loss of other coverage

☐ **Other** _____

☐ **Date of Event** _____

Dependent Information

Spouse's Last Name	First Name	MI	Sex: ☐ Male ☐ Female	Spouse's Date of Birth

Spouse's Employer (Complete Name & Address)	Spouse's Social Security #

DEPENDENT CHILDREN INFORMATION Last Name	First Name	Middle Initial	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 _____ Eff Date? _____
   Medicare ID #_____
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 elections that I make unless there is a qualifying event.

EMPLOYEE SIGNATURE:_____ **DATE:**_____

PLEASE RETURN THIS FORM FOR APPROVAL AND PROCESSING.

(over)