Enrollment & Change Form

☐ Initial Enrollment
☐ Rehire
☐ Change to Existing Enrollment*

ColCal Inc. 76412904

EMPLOYER USE ONLY:

DATE OF FULL-TIME HIRE	LOCATION/DIVISION	☐ SALARIED ☐ HOURLY	SALARY (for salary based benefits)	OCCUPATION/JOB TITLE

Employee Information (please print, using blue or black ink)

Social Security Number	Last Name	First Name	MI

Mailing Address	Home Phone (include area code)	Work Phone (include area code)

City	State	ZIP Code	Date of Birth	Gender

Marital Status: ☐ Single ☐Married ☐Legally ☐ Divorced ☐Common-law/Domestic Partnership (Notarized Affidavit Required, see below*)

Benefit Choices

☐$1000 Plan ☐ $5000 Plan

☐ Employee Only
☐ Employee + Spouse
☐ Employee + Child(ren)
☐ Employee + Family

☐ No Medical (please complete waiver section)

☐ Dental

☐ Employee Only
☐ Employee + Spouse
☐ Employee + Child(ren)
☐ Employee + Family
☐ No Dental

*COMPLETE THIS SECTION ONLY IF YOU **DO NOT** WANT COVERAGE*

Waive Coverage for: ☐ Employee ☐ Spouse ☐ Child(ren)
Reason: ☐ Cost ☐ Other Coverage (Attach copy of ID card)
I understand I (we) will not be able to enroll later unless special enrollment requirements are met or at open enrollment (if available). Pre-existing limitations may apply.

(sign here) ______________________________

If available:
☐ Employee Life/AD&D ☐ Spouse/Dependent Life

Primary Life Beneficiary	Relationship	Secondary Life Beneficiary	Relationship

Change Information (Leave blank if initial enrollment or rehire)*

ADDITIONS

REASON FOR ADDITION:

☐ Newborn – date of birth ____________________
☐ Adoption – date of placement ________________
☐ Marriage – date of marriage _________________
☐ **Involuntary** loss of other coverage (Proof Required) Date:__________________________
☐ Other (explain)____________________________

COMPLETE DEPENDENT INFORMATION SECTION, BELOW

TERMINATIONS

REASON FOR TERMINATION:

☐ Divorce or Legal Separation (include ex-spouse's mailing address)
____
☐ Dependent child no longer eligible
☐ Voluntary termination (still eligible)_____________ (explain)
☐ Other (explain)___________________________

Qualifying Event Date: ______________________

Terminate Coverage for: _____________________

OTHER CHANGES

☐ Name Change

Former name______________________

New name _______________________

☐ Address/Phone # Change

☐ Beneficiary Change: PLEASE MAKE CHANGES IN THE BENEFICIARY DESIGNATION BOXES ABOVE

☐ Other (explain)___________________

Dependent Information (list only those members affected by the requested enrollment or change)

Mbr	Name (include last name if different)	Relation to Employee	Gender	Date of Birth (MM/DD/YY)	Social Security #
EE	**SEE ABOVE**	SELF	**SEE ABOVE**		
SP		☐ Spouse by marriage ☐ Common Law Spouse or Domestic Partner			
CH					
CH					
CH					
CH					

* Please note: if Common Law Spouses and/or Domestic Partners are not eligible under your plan or in your state, a marriage certificate may be required.

For dependents age 19 and over, verification of dependent status, full-time student status **or** handicapped dependent status may be required prior to enrollment. Please check with your Employer or UMR for details and forms.

Are you or any of your dependents listed above currently covered under any other medical plan, including Medicare? ☐ No ☐ Yes, please provide the following information:

Member(s) Name(s)	Employer Name	Insurance Company or Employer Name, Address & Phone Number	Policy Number	Medicare A, B or both	Medicare HIC #

PLEASE PROVIDE A CERTIFICATE OF CREDITABLE COVERAGE (HIPAA CERTIFICATE) IF YOU HAVE HAD OTHER GROUP MEDICAL COVERAGE WITHIN THE LAST 12 MONTHS. If there is not proof of prior creditable coverage, pre-existing limitations as defined in the plan document may apply.

I acknowledge receipt of the benefit enrollment materials and certify that, to the best of my knowledge, the information shown on this form is correct and complete. I understand that I may not be able to make changes to these elections except in case of special enrollment or open enrollment (if available).

Employee Signature Date Signed

For UMR Use Only

Effective Date	Location #	Plan #/Coverage/Class	Volumes	ID Card	Adjustment