WCA Group Health Trust

Group Plan
New Hire Enrollment & Change Form
Please Print

UMR
A United-Healthcare Group Company

Employer Information

Employer: FOND DU LAC COUNTY Group Number 76-440020

☐ 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)

Women's Health and Cancer Rights Act Notice

On October 21, 1998, the federal government passed the Women's Health and Cancer Rights Act of 1998. As part of our plan's compliance with this Act, we are required to provide you with this enrollment notice outlining the coverage that this law requires our plan to provide.

The WCA Group Health Trust has always provided coverage for medically necessary mastectomies. This coverage includes procedures to reconstruct the breast on which the mastectomy was performed, as well as the cost of necessary prostheses (implants, special bras, etc.) and treatment of any physical complications resulting from any stage of the mastectomy. However, as a result of this federal law, the plan now provides coverage for surgery and reconstruction of the other breast to achieve a symmetrical appearance with the breast on which the mastectomy is performed.

The following benefits are required to be provided if benefits are provided for a mastectomy:

1. Coverage for reconstruction of the breast on which the mastectomy is performed.
2. Coverage for surgery and reconstruction of the other breast to produce a symmetrical appearance with the breast on which the mastectomy is performed.
3. Coverage for prostheses and physical complications resulting for any state of the mastectomy, including lymphedemas.

These benefits are subject to the same deductible, copays and coinsurance that apply to mastectomy benefits under this plan.