HEALTH PLAN EMPLOYEE ENROLLMENT / CHANGE FORM

Administered by: Arise Administrators

□ New Employee
□ Retiree Plan – Eligible until age 65
□ Change
□ COBRA – Eligible up to _____ months
□ Add dependent under age 26 Law

Employer Name City of Green Bay	**Group Number** A00104		**Employee Job Location**
Employee Start Date	**Division**		**Job Title**
Date Notified Arise Administrators	**Date Payroll Payment Changes Completed**		
Employee Social Security #	**EE Name:**	**Last**	**First**
Address	**City**	**State**	**Zip**
Date of Birth	**Sex**	**Marital Status**	**Home Telephone #**

Do you or any family member(s) currently have other Health coverage? ☐ Yes, Single ☐ Yes, Family ☐ No

If yes to the above question, complete the following: Person's name: _____

Employer Name: _____ Carrier Name: _____ Plan # _____

Medical Plan: ☐ Plan 3 ☐ Retiree High Deductible Plan

Coverage Type: ☐ Employee Only ☐ Family

Primary Care Physician

Name of Individual: _____ **Physician Name:** _____
Name of Individual: _____ **Physician Name:** _____
Name of Individual: _____ **Physician Name:** _____
Name of Individual: _____ **Physician Name:** _____
Name of Individual: _____ **Physician Name:** _____

☐ Waive, no other coverage** Please indicate reason: _____

☐ Waive, due to other coverage** Name of individual(s) waiving coverage _____

** If **waiving** coverage, or an employee with dependents electing only employee coverage, read **NOTICE TO LATE ENROLLEES** on the reverse side.

** If you and your eligible dependents are **waiving ALL coverages** offered under this plan, **please sign and date below.**

I proclaim that I was not pressured or forced by the employer named above, the writing agent, or Arise Administrators into waiving the above noted coverage. I freely and voluntarily waive the above noted coverage.

_____ _____
EMPLOYEE SIGNATURE DATE

IF YOU ARE ELECTING OR CHANGING ANY OF THE ABOVE COVERAGES, PLEASE COMPLETE THE REMAINING SECTIONS OF THIS FORM ON THE REVERSE SIDE.

NOTICE: If your plan is provided by your employer on a self-funded basis, Arise Administrators is providing administrative services for benefits only.

SEE NEXT PAGE

COMPLETE THIS SECTION IF ELECTING DEPENDENT COVERAGE

NAME:	Last	First	SS #	Birth date	Sex				Does Child reside with you	Do you provide 50% + support	**Credits this semester
Spouse	_____	_____	_____	_____	____						
	Last	First	SS #	Birth date	Sex	Natural Child	Step Child	Other *			
Child 1	_____	_____	_____	_____	____	☐	☐	☐	_____	_____	_____
Child 2	_____	_____	_____	_____	____	☐	☐	☐	_____	_____	_____
Child 3	_____	_____	_____	_____	____	☐	☐	☐	_____	_____	_____
Child 4	_____	_____	_____	_____	____	☐	☐	☐	_____	_____	_____
Child 5	_____	_____	_____	_____	____	☐	☐	☐	_____	_____	_____

* If "OTHER", Please explain: _____

COMPLETE THIS SECTION IF MAKING CHANGES

Effective date of change: _____ Please specify change and update in appropriate section.

☐ Employee name change ☐ Employee address change ☐ Job location change ☐ Job title change

☐ Return to work ☐ Other coverage change ☐ Date of Marriage: _____

☐ Other _____ ☐ Date of Divorce: _____

☐ Add dependents(list names) _____ ☐ Remove dependents (list names) _____ Reason: _____

☐ Voluntary Terminate coverage _____ ☐ State/Federal Continuation

☐ Employment termination: Reason _____ Last day worked _____ Date coverage terminated_____

I hereby authorize any person, including physicians, hospitals, insurance companies and service organizations, to release to Arise Administrators any medical information regarding me or my dependents for any purpose, including application for insurance, claim adjudication, medical record audit and peer review activities. This authorization shall be valid for the duration of my coverage under this plan.

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 by Arise Administrators.

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

For Retiree High Deductible Plan Only: I hereby certify my understanding that upon enrollment in the Retiree High Deductible Plan, I cannot switch to any other health insurance plan offered by the City of Green Bay.

_____ _____

EMPLOYEE SIGNATURE DATE

NOTICE TO LATE ENROLLEES

If you are not covered within 30 days after becoming eligible for health coverage, the following will apply.

This Plan has an exclusion for Pre-Existing Conditions. Benefits will not be paid for Covered Expenses for a Pre-Existing Condition for 18 consecutive months beginning on the Enrollment Date. Charges incurred after such 18 month period are eligible for benefits as provided under this Plan.

A Pre-Existing Condition means an Illness or Injury for which medical advice, diagnosis, care, or treatment was recommended or received within six consecutive months prior to the Covered Person's Enrollment Date. Medical advice, diagnosis, care, or treatment (including taking prescription drugs) is taken into account only if it is recommended or received from a licensed Physician.