



Group Plan
New Hire Enrollment & Change Form
Please Print

UMR
A United-Healthcare Group Company

WCA GROUP HEALTH TRUST

Employer Information	Employer: <u>SCHOOL DISTRICT OF JEFFERSON</u> Group Number <u>76-440224</u> <input type="checkbox"/> NEW ENROLLMENT <input type="checkbox"/> CHANGE Effective Date of Coverage _____ Date of Hire: _____						
Employee Information	Last Name		First Name	MI	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Social Security No. or ID#
	Street Address			City	State	Zip Code	Home Phone
	Marital Status: <input type="checkbox"/> Single		<input type="checkbox"/> Married		<input type="checkbox"/> Legally Separated		<input type="checkbox"/> Divorced
		Date: _____		Date: _____		Date: _____	
Coverage Type	I AM ENROLLING IN THE FOLLOWING COVERAGES:		I AM WAIVING COVERAGE FOR:		I AM REQUESTING THE FOLLOWING CHANGES:		
	<u>MEDICAL</u> <input type="checkbox"/> Single <input type="checkbox"/> Family		<u>MEDICAL</u> <input type="checkbox"/> Single <input type="checkbox"/> Family		<input type="checkbox"/> DROP; Reason: <input type="checkbox"/> Divorce; <input type="checkbox"/> Legal Separation; <input type="checkbox"/> Voluntarily Drop Address of dropped spouse/dependent: _____		
	<i>I hereby apply for coverage & authorize deductions from my earnings for the amount required, if any, to cover any contribution for coverage.</i>		<i>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>		<input type="checkbox"/> Widowed; Date: _____ <input type="checkbox"/> ADD; Reason: <input type="checkbox"/> Spouse, due to marriage <input type="checkbox"/> Newborn <input type="checkbox"/> Adoption <input type="checkbox"/> Placed for Adoption <input type="checkbox"/> Step Child <input type="checkbox"/> Grandchild <input type="checkbox"/> Loss of other coverage <input type="checkbox"/> Other _____ <input type="checkbox"/> Date of Event _____		
Dependent Information	Spouse's Last Name		First Name		MI	Sex: <input type="checkbox"/> Male <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No; Person's Name _____ Eff Date? _____ Medicare ID # _____						
	2. Do you or any dependents have any other MEDICAL coverage? <input type="checkbox"/> Yes <input type="checkbox"/> 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 until the next open enrollment, unless there is a qualifying event.

EMPLOYEE SIGNATURE: _____ **DATE:** _____

PLEASE RETURN THIS FORM TO YOUR EMPLOYER 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.