Employee Enrollment / Change For

☐ Open Enrollment ☐ New Employee

☐ Change (complete change section on reverse side)

Benefits Administered by UMR

CLAIMS ADMINISTRATION:
PO BOX 30541, Salt Lake City UT 84130

ER NAME: LONG Building Technologies,Inc	GROUP NUMBER **76-070072**	EE JOB LOCATION: CO NV UT WY
EE DOH:	EFFECTIVE DATE	HOURS WORKED WEEKLY

SOCIAL SECURITY NUMBER:			EMAIL ADDRESS:
NAME: LAST	FIRST	M.I.	
ADDRESS		CITY	ST ZIP
DATE OF BIRTH:	SEX	MARITAL STATUS	HOME PH#:

This Health Plan has a Pre-existing illness provision for 12 months. Proof of Creditable Health Coverage may reduce this time period.
Have you attached a Certificate of Creditable Health Coverage for You and/or all Dependents? ☐ YES ☐ NO
If NO, contact your prior plan, employer, or insurer to obtain a copy. If a certificate is not available, other forms of proof may be submitted.

Do you or any family member currently have other health coverage? ☐Yes, single ☐Yes, family ☐No **Answer based on effective date of enrollment or change.**
If yes to the above question, complete the following: Person's name _____
Employer Name _____ Carrier Name_____ Plan Number_____

☐ **Medical Plan – Standard Plan**
☐ Employee=$65/mo ☐ Employee+Spouse=$245/mo ☐ Family=$455/mo ☐ Employee+Child(ren)=$220/mo

☐ **Medical Plan – Buy Up Plan**
☐ Employee=$165/mo ☐ Employee+Spouse = $550/mo ☐ Family=$950/mo ☐Employee+Child(ren)=$470/mo

COMPLETE THIS SECTION IF ELECTING DEPENDENT COVERAGE for MEDICAL

Last First MI		BIRTH DATE	Biological Child	Step Child	Other	Does child reside with you?	Do you provide 50% support?	Do you claim this dependent as an exemption for Federal Income tax purposes?	Credits this semester
Spouse Name _____ SSN:	M or F	__/___/___							
Child Name 1_____ SSN:	M or F	__/___/___	☐	☐	☐	_____	_____	_____	_____
2_____ SSN:	M or F	__/___/___	☐	☐	☐	_____	_____	_____	_____
3_____ SSN:	M or F	__/___/___	☐	☐	☐	_____	_____	_____	_____
4_____ SSN:	M or F	__/___/___	☐	☐	☐	_____	_____	_____	_____
5_____ SSN:	M or F	__/___/___	☐	☐	☐	_____	_____	_____	_____

Please attach verification of full-time status. What semester is student registered for?
If "OTHER", please explain _____

COMPLETE THIS SECTION IF MAKING CHANGES.

Effective date of change: _____ **Please specify change and update in appropriate section.**
☐Name change ☐Address change ☐Location change ☐Return to work ☐Other coverage change ☐Date of marriage_____
☐Other _____ ☐Date of Divorce_____ ☐Add dependents (list names above)
☐Remove dependents (list names) _____ Reason for ADD or REMOVAL of dependents: _____
☐Add coverage (list names above) ☐Voluntarily Terminate HEALTH coverage

WAIVING COVERAGE: If you decline benefits for yourself or your dependents, you may in the future be able to enroll yourself or your dependents in this benefit plan. You may have an opportunity to enroll during your annual enrollment period or if your family status changes. For specific plan language contact HR. I Freely and voluntarily waive MEDICAL coverage through UMR. Sign and date here if waiving coverage:

I hereby certify all of the above information is true and correct. I understand coverage will not be effective until all questions regarding eligibility for coverage have been satisfactorily resolved by UMR. I understand I may not change the coverage elections I make on the Enrollment/Change Form until the Plan's next open enrollment period or unless otherwise permitted by the Plan. Please refer to your Benefit Plan Document for specific details of your benefit plan. I hereby apply for coverage and authorize deductions from my earnings for the amount required, if any, to cover any contribution for coverage.

_____ _____
EMPLOYEE SIGNATURE DATE