UMR

CHECK ALL APPLICABLE BOXES FOR ENROLLMENT OR CHANGE

Englefield Oil Company, Inc.
PREMIUM/STANDARD PLAN
ENROLLMENT AND CHANGE FORM
(Changes must be submitted within 30 days of event. Loss of Medicaid/CHIP must be submitted within 60 days of the event.)

CUSTOMER ID: E2
Group#090109E2
Email Address: enrollment@umr.com
Fax: 513-619-3059

☐ become enrolled	☐ change address
☐ re-enroll	☐ change name
☐ terminate	☐ change other insurance info
☐ add spouse and/or dependent(s)	☐ change location
☐ drop spouse and/or dependent(s)	☐ change department
☐ voluntary drop coverage	☐ change plan code
☐ loss/gain of Medicaid/CHIP	
Explanation:	
Beneficiary: _____ **Relationship** _____	
Contingent beneficiary _____ **Relationship** _____	

SELECT THE TYPE(S) OF COVERAGE DESIRED

Medical	☐ **Single**	☐ **Employee + 1**	☐ **Family**	☐ **Waive**
Dental	☐ **Single**	☐ **Employee + 1**	☐ **Family**	☐ **Waive**
Vision	☐ **Single**	☐ **Employee + 1**	☐ **Family**	☐ **Waive**

EMPLOYEES FULL NAME (Please Print) Last First MI

EMPLOYEE SOCIAL SECURITY NO.

EMPLOYEE DATE OF BIRTH

SEX OF EMPLOYEE ☐ Male ☐ Female

EMPLOYEE'S HOME ADDRESS (NUMBER AND STREET)

CITY

STATE

ZIP CODE

HOME TELEPHONE NO. (include area code)

Number of Hours Worked Weekly: _____

If you selected *Family* or *2 Party Coverage*, complete the following information for each dependent (H-Husband W-Wife S-Son D-Daughter) to be covered.

DEPENDENT (H W S D)	FULL NAME	SEX (M/F)	BIRTHDAY (MO/DAY/YR)	SOCIAL SECURITY NUMBER	OTHER INSURANCE COVERAGE INCLUDING MEDICARE (List Employer Name, Address, Tax ID Number, Name of Carrier, Eff. Date of Coverage & Group Number). If no other coverage, state NONE.	This Plan's Pre-Existing Conditions Limitation may be waived w/ verification of continuous coverage. Certificate attached?	
						☐ Yes	☐ No
						☐ Yes	☐ No
						☐ Yes	☐ No
						☐ Yes	☐ No
						☐ Yes	☐ No

Any misrepresentation or misstatement of a material fact made on this form or any form requesting benefits under the plan shall terminate an employee's eligibility and that of his/her eligible dependents, render invalid all benefits under the plan and require forthwith repayment of any benefit received pursuant to such misrepresentation or misstatement. I authorize the company to make payroll deductions if any required to participate in the benefit plan.

EMPLOYEE'S SIGNATURE _____ DATE SIGNED / /

TO BE COMPLETED BY COMPANY REPRESENTATIVE

MEDICAL PLAN	DENTAL PLAN	VISION PLAN	STD PLAN	LOCATION
E2UHPM/E2UHSM	E2DEN1	E2VIS1	E2STD1	

CERTIFICATION(*See Below)	DATE OF HIRE	ORIGINAL EFFECTIVE DATE	TERM DATE	EFFECTIVE DATE OF CHANGE
☐ YES ☐ NO				

*If no Certificates attached, has employee been continuously covered for 12 months (18 months if late enrollee)?

REPRESENTATIVE'S SIGNATURE _____ DATE SIGNED / /

E 101 ELECTRONIC PDF 9/09

PRINT EMAIL RESET