UMR

CHECK ALL APPLICABLE BOXES FOR ENROLLMENT OR CHANGE

Englefield Oil Company, Inc.
ECONOMY 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:

Accidental Death/Dismemberment Insurance Beneficiary Election:
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
E2UHEM	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