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MPLOYER NAME City of Stevens Point	GROUP NUMB 76415944	ER EM	IPLOYEE START DAT	FE EFFECTIVE DATE
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yes to the above question mployer Name				 mber
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IF YOU ARE ELECTING OR CHANGING ANY OF THE ABOVE COVERAGES, PLEASE COMPLETE THE REMAINING SECTIONS OF THIS FORM.

COM	PLETE THIS SECTION IF MAKING CHANGES.
COM	Effective date of change: Please specify change and update in appropriate section. Employee name change Employee address change Job location change Earnings change Earnings change Return to work Other coverage change Date of marriage Date of Divorce Other Eligible for Medicaid/CHIP subsidy Loss of Eligibility for Medicaid/CHIP subsidy Add dependents Remove dependents (list names) Reason:
	Voluntarily Terminate coverage (Indicate which coverages)
	State/Federal Continuation Employee Signature Required
	Employment termination: Reason: Last day worked Date coverage terminated
	Important: 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. If you decline benefits because of other group health or insurance coverage, and state so in writing, you may have the opportunity to enroll under HIPAA Special Enrollment because of loss of that coverage. By checking the box below, you are attesting that you are declining enrollment in this plan because you are enrolled in other group health coverage: I attest that I am declining group health coverage because I am currently enrolled in other group health or insurance coverage. For specific plan language contact your Human Resources Representative CERTIFICATION: I freely and voluntarily waive all coverage noted above.
I un	ctions regarding eligibility for coverage have been satisfactorily resolved. Iderstand that I may not change the coverage elections that I make on the Employee Enrollment/Change Form until the plan's open/annual enrollment period or unless otherwise permitted by the Plan. Is refer to your Employee Benefit Booklet for specific details of your benefit plan.
	hereby apply for coverage and authorize deductions from my earnings for the amount required, if any, to cover any ontribution for coverage.

DATE

EMPLOYEE SIGNATURE