

**City of Milwaukee
Department of Employee Relations
Employee Benefits Division**

HOW TO COMPLETE THE HEALTH PLAN ENROLLMENT APPLICATION

GENERAL INSTRUCTIONS

Read this entire section

- 1) **Write the name of the Health Plan you have selected in Box 1 of Section A of the Health Plan Enrollment Form.** All Active employees **must** include their Employee Identification Number (Employee ID #) on the health plan enrollment application. If you fail to include this information in Box 2, the health plan enrollment application will be returned to you.
- 2) Complete all sections of the Health Plan Enrollment Form as they apply to you. In Section B, list each eligible dependent, including their Social Security Number and their relationship to you (the subscriber). Please mark the appropriate box. **Social Security numbers for each dependent are required.** Failure to provide the complete information where it is required will cause delays in setting up your membership as well as delays in the issuance of Medical ID cards.
- 3) **ACTIVE EMPLOYEES:** Return your completed application to the Department of Employee Relations (DER), City Hall Room 706 within the designated Open Enrollment period. HACM, WCD & MEDC employees return your completed application to your departmental payroll personnel. Late applications will not be accepted for any plan changes. See the Open Enrollment booklet for more information on the Open Enrollment period. **DO NOT** mail your application to the Health Plan.
- 4) **RETIREES, DISABILITY RETIREES, and SURVIVING SPOUSE ENROLLEES:** Mail your completed application to **Employees' Retirement System, Heartland Funds Building, 789 N. Water Street, Suite 300, Milwaukee, WI 53202.** **DO NOT** mail your application to the Health Plan.
- 5) A Domestic Partnership registration must be completed before enrolling a Domestic Partner for Health and/or Dental Insurance.

SPECIFIC INSTRUCTIONS

Read the instructions for the HEALTH PLAN of your choice.

AVAILABLE HEALTH PLAN CHOICES

UNITEDHEALTHCARE (UHC) CHOICE PLAN

SECTION A Write "**UnitedHealthcare (UHC) Choice Plan**" in BOX 1. Without exception, all Active employees **must** complete BOX 2 by entering the Employee Identification Number (Employee ID #) on the health plan enrollment application. This is required of all Active employees.

SECTION B Please list each eligible dependent and include the Date of Birth, the Social Security Number and their relationship to you.

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BASIC HEALTH PLAN - (Anthem Blue Cross Blue Shield)

SECTION A Write "**Basic Plan**" in BOX 1. Without exception, all Active employees must complete Box 2 by entering your Employee Identification Number (Employee ID #) on the health plan enrollment application. This is required of all Active employees.

SecureHorizon Medicare Direct - (United Healthcare Insurance Company) This plan is for Medicare eligible members, only.

SECTION A Write "**SecureHorizon Medicare Direct**" in BOX 1. Complete BOX 2 as indicated above.

SECTION B For each eligible dependent, list each eligible dependent and include the Date of Birth, the Social Security Number and their relationship to you.

Complete all of the appropriate areas of Sections A, B, C, D, and E of the application for all of the health plan selections.

**ALL ENROLLMENT FORMS MUST BE SIGNED AND DATED BY THE EMPLOYEE,
THE COBRA ENROLLEE OR THE RETIREE.**