



SIG ENROLLMENT / CHANGE FORM

District Name	Bargaining Unit	Date of Hire	Effective Date
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I. ENROLLMENT/CHANGE REASON

<input type="checkbox"/> New Enrollment	<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Add Dependent	<input type="checkbox"/> Voluntary Termination
<input type="checkbox"/> Status Change	<input type="checkbox"/> Deceased	<input type="checkbox"/> Delete Dependent	<input type="checkbox"/> Involuntary Termination
<input type="checkbox"/> Loss of Coverage (provide HIPAA Cert)	<input type="checkbox"/> Address Change	<input type="checkbox"/> Name Change	<input type="checkbox"/> Retirement

Event: _____ Event Date: _____

II. PLAN CHOICES

Medical Plan <input type="checkbox"/> Plan Name _____ Group # _____ <p style="text-align: center;">Please complete and attach carrier's enrollment form.</p>	Other Coverage <input type="checkbox"/> Delta Dental Plan <input type="checkbox"/> Vision Service Plan <input type="checkbox"/> Optum HSA
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III. PERSONAL INFORMATION

1. Name (Last, First, M.I.)		2. Social Security Number - -	
3. Address		4. Phone No. ()	
5. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	6. Date of Birth (MM/DD/YYYY) / /	7. Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	8. Email Address
9. Annual Cap Amount	10. Monthly Payroll Frequency <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12	11. <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time (over 20 hrs)	

IV. FAMILY INFORMATION

	Last Name, First Name, MI	Gender	Social Security Number	Date of Birth	<input type="checkbox"/> Add <input type="checkbox"/> Delete
<input type="checkbox"/> Spouse <input type="checkbox"/> Registered Domestic Partner		<input type="checkbox"/> M <input type="checkbox"/> F	- -		<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
<input type="checkbox"/> Son <input type="checkbox"/> Daughter			- -		<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
<input type="checkbox"/> Son <input type="checkbox"/> Daughter			- -		<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
<input type="checkbox"/> Son <input type="checkbox"/> Daughter			- -		<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
<input type="checkbox"/> Son <input type="checkbox"/> Daughter			- -		<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision

I authorize any payroll deduction that may be required towards the cost of this coverage. I certify that the above information is true and correct to the best of my knowledge. I understand that changes can only be made if I experience a qualifying family status change, in which case the change must be consistent with that event, or as may otherwise be provided by the group contract.

Signature _____ Date _____

Employer Section: Must be completed by District Office			Benefit Coordinator: Please initial: _____		
Medical Plan Code	KP Code	Dental Plan Code	Vision Plan Code	Life Amount	Health Savings Acct
_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> Chg	<input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> Chg	<input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> Chg	<input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> Chg	<input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> Chg	<input type="checkbox"/> Add <input type="checkbox"/> Term <input type="checkbox"/> Chg
Old Code	Old Code	Old Code	Old Code	Old Code	
____/____/____	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____
Effective Date	Effective Date	Effective Date	Effective Date	Effective Date	Effective Date