SIG ENROLLMENT / CHANGE FORM

District Name	Effective Date	Date of Hire

I. ENROLLMENT/CHANGE REASON

☐ New Enrollment	☐ Open Enrollment	☐ Add Dependent	☐ Termination
☐ Status Change	☐ Retirement	☐ Delete Dependent	☐ Deceased
☐ Loss of Coverage (provide HIPAA Cert)		☐ Name Change	☐ Address Change

Event: Event Date:

II. PLAN CHOICES

Medical Plan

☐ Plan Name _____ Group #_____

Please complete and attach carrier's enrollment form.

Other Coverage

☐ Delta Dental Plan
☐ Vision Service Plan
☐ Optum HSA

III. PERSONAL INFORMATION

1. Name (Last, First, M.I.)			2. Social Security Number - -
3. Address	City, State, Zip		4. Phone No. ( )
5. Gender ☐ Male ☐ Female	6. Date of Birth (MM/DD/YYYY) / /	7. Marital Status ☐ Single ☐ Married	8. Email Address
9. Bargaining Group	10. Monthly Payroll Frequency ☐10 ☐11 ☐12		11. ☐ Full Time ☐ Part Time (over 20 hrs)

IV. FAMILY INFORMATION

	Last Name, First Name, MI	Gender	Social Security Number	Date of Birth	☐ Add ☐ Delete
☐ Spouse ☐ Registered Domestic Partner		☐ M ☐ F	- -		☐ Medical ☐ Dental ☐ Vision
☐ Son ☐ Daughter			- -		☐ Medical ☐ Dental ☐ Vision
☐ Son ☐ Daughter			- -		☐ Medical ☐ Dental ☐ Vision
☐ Son ☐ Daughter			- -		☐ Medical ☐ Dental ☐ Vision
☐ Son ☐ Daughter			- -		☐ Medical ☐ Dental ☐ 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
☐ Add ☐ Term ☐ Chg	☐ Add ☐ Term ☐ Chg	☐ Add ☐ Term ☐ Chg	☐ Add ☐ Term ☐ Chg	☐ Add ☐ Term ☐ Chg	☐Add ☐Term ☐Chg
Old Code	Old Code	Old Code	Old Code	Old Code	
_____ / _____ / _____ Effective Date	_____ / _____ / _____ Effective Date	_____ / _____ / _____ Effective Date	_____ / _____ / _____ Effective Date	_____ / _____ / _____ Effective Date	____ / ____ / ____ Effective Date