



APPLICATION FOR GROUP EMPLOYEE BENEFIT PLANS

**1** Reason for Change (complete all)  
 New Enrollment (complete all)  
 Change (complete reason)  
 Termination (name, SS#, & termination date)  
 Retirement (name, SS#, & termination date)

**2** Add/Delete Spouse/Dependents  
 Add new baby  Delete spouse   
 Add new spouse  Delete child(ren)   
 Add new child(ren)  Delete domestic partner   
 Add domestic partner

**3** School District/Community College  
 Date of Hire: / /

**4** Employee's Name: Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_ SSN \_\_\_\_\_  
 Address: Street \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone No. ( ) \_\_\_\_\_

**5** Are you transferring from another district?  Yes  No   
 Name of district: \_\_\_\_\_

**6** Birthdate: / /

**7** Employee Job Title:  
 Administrative  Full Time  
 Board  Part Time  
 Confidential  Certificated Mgmt.

**8** Are you or your dependents covered under any other Medical or Dental Group Plan?  
 Yes  No if yes,  Self  Spouse  Children  
 Employer: \_\_\_\_\_  
 Carrier(s): \_\_\_\_\_ Policy # (s) \_\_\_\_\_

**9**  Single  Married  Divorced  
 Male  Female

**10** Coverage:  
 Medical: Yes  No   
 Dental: Yes  No   
 Vision: Yes  No   
 (For a first-time, Promoted Employee a No is a Declaration of Coverage)

**11** Retiree & Medicare Information:  
 Are you retired?  Yes  No On Medicare? Part A?  Yes  No Part B?  Yes  No  
 Spouse retired?  Yes  No On Medicare? Part A?  Yes  No Part B?  Yes  No

**12**  Add Eligible Dependent(s): Legal Spouse and/or IRS Dependent Children  Delete Dependents

| Circle Relationships | Last Name | Eligible Dependents |    |    | Date of Birth | Social Security Number | Circle Choices: |        | Reason: | Effective Date |
|----------------------|-----------|---------------------|----|----|---------------|------------------------|-----------------|--------|---------|----------------|
|                      |           | First               | MI | Mo |               |                        | Day             | Year   |         |                |
| Employee             |           |                     |    |    |               |                        | Medical         | Dental | Vision  |                |
| Spouse/partner       |           |                     |    |    |               |                        | Medical         | Dental | Vision  |                |
| Son                  |           |                     |    |    |               |                        | Medical         | Dental | Vision  |                |
| Daughter             |           |                     |    |    |               |                        | Medical         | Dental | Vision  |                |
| Son                  |           |                     |    |    |               |                        | Medical         | Dental | Vision  |                |
| Daughter             |           |                     |    |    |               |                        | Medical         | Dental | Vision  |                |
| Son                  |           |                     |    |    |               |                        | Medical         | Dental | Vision  |                |
| Daughter             |           |                     |    |    |               |                        | Medical         | Dental | Vision  |                |
| Son                  |           |                     |    |    |               |                        | Medical         | Dental | Vision  |                |
| Daughter             |           |                     |    |    |               |                        | Medical         | Dental | Vision  |                |
| Son                  |           |                     |    |    |               |                        | Medical         | Dental | Vision  |                |
| Daughter             |           |                     |    |    |               |                        | Medical         | Dental | Vision  |                |

**13** Qualifying Event:  
 Termination  Death of Employee  
 Reduction in Hours  Divorce or Separation  
 Other  Loss of dep child eligibility  
 Date of Event: / / Date of loss of coverage: / /

**14** I approve the above authorization and hereby apply for group benefits provided under my employer's group plan(s) and authorize payroll deductions, if required, for the cost of the coverage. My signature below indicates acceptance of these terms and that the information I have entered above is true and correct. I understand that my health carrier(s) reserve the right to rescind or terminate coverage if any material misrepresentation is made on this Enrollment Application.

**15** Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

**16** EMPLOYER'S SECTION  
 Employee's Contribution \$ \_\_\_\_\_  
 Date of Eligibility/Termination \_\_\_\_\_  
 Medical Code: \_\_\_\_\_ Dental Code: \_\_\_\_\_ Vision Code: \_\_\_\_\_  
 COBRA Information:  
 Termination  Death of Employee  
 Reduction in Hours  Divorce or Separation  
 Other  Loss of dep child eligibility  
 Date of Event: / / Date of loss of coverage: / /