



SECTION I - TO BE COMPLETED BY EMPLOYEE/RETIREE

Use this form to select/change a medical, dental and/or vision plan and coverage level.

Reason for completing form: New Hire Current employee enrolling Change Termination

Type of Change: Name Address Add spouse/dependent Remove spouse/dependent

Hire Date: _____ **Benefit Type:** Medical Dental Vision

Name (First, Middle, Last)	Social Security Number	Date of Birth	Male/Female	Add or Drop
Employee/Retiree			<input type="checkbox"/> M <input type="checkbox"/> F	
Spouse			<input type="checkbox"/> M <input type="checkbox"/> F	
Dep			<input type="checkbox"/> M <input type="checkbox"/> F	
Dep			<input type="checkbox"/> M <input type="checkbox"/> F	
Dep			<input type="checkbox"/> M <input type="checkbox"/> F	

Street Address _____

City _____ State _____ ZIP Code _____

SECTION II - TO BE COMPLETED BY EMPLOYEE/RETIREE: ELECTION OF BENEFITS

Election(s)			Coverage Level/Tier				
Medical	<input type="checkbox"/> EPO	<input type="checkbox"/> PPO	<input type="checkbox"/> EE	<input type="checkbox"/> EE + CH	<input type="checkbox"/> EE + CHN	<input type="checkbox"/> EE + SP	<input type="checkbox"/> FAM
Dental			<input type="checkbox"/> EE	<input type="checkbox"/> FAM			
Vision			<input type="checkbox"/> EE	<input type="checkbox"/> FAM			

Return this completed form within 30 days of your date of hire, probationary period end date, or qualifying life event along with any required documentation (ie. marriage certificate, birth certificate, etc.) Refer to the Instructions for Benefits Elections/Changes to determine what documents you need to provide. Your benefits will not be updated until all documentation is received.

I certify that the above information is true and correct. By not enrolling in benefits within 30 days of hire (or end of probationary period) or within 30 days of a qualifying life event, I will be unable to enroll or make changes again until the next annual Open Enrollment period.

Employee/Retiree Signature: _____ **Date:** _____

SECTION III - TO BE COMPLETED BY SCHOOL DISTRICT

Effective Date of Change: _____ **Date Section I Recieved:** _____

Qualifying Life Event	<input type="checkbox"/> Act 110/Act 43 Eligible	<input type="checkbox"/> Divorce	<input type="checkbox"/> Newborn	<input type="checkbox"/> Termination
	<input type="checkbox"/> Adoption	<input type="checkbox"/> Legal Guardianship	<input type="checkbox"/> Over Age Dependent	<input type="checkbox"/> COBRA - <input type="checkbox"/> Med <input type="checkbox"/> Dental <input type="checkbox"/> Vision
	<input type="checkbox"/> Court Ordered	<input type="checkbox"/> Marriage	<input type="checkbox"/> Resignation - Voluntary	
	<input type="checkbox"/> Death	<input type="checkbox"/> Medicare Entitlement	<input type="checkbox"/> Retirement	

Signature of District Representative: _____ **Date:** _____