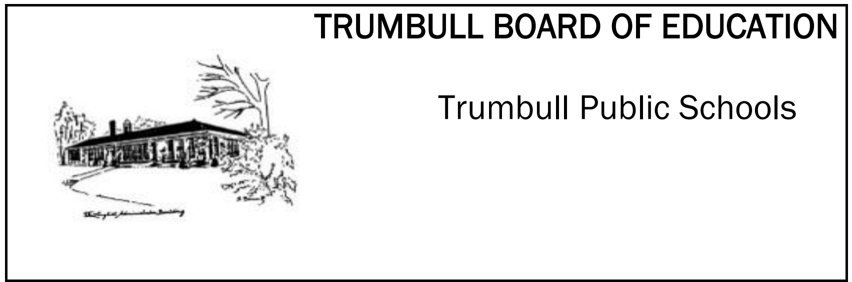
Health Insurance Enrollment / Change Form

New Enrollee	☐
Name Change	☐
Address Change	☐
Add Coverage	☐
Term Coverage	☐
Add Dependent	☐
Term Dependent	☐

TRUMBULL BOARD OF EDUCATION



Trumbull Public Schools

Employee Name (Last, First)		EFFECTIVE DATE	7/1/2023
Street Address		EMP NO.	
City, State & Zip		GROUP	
Phone No. (Home) **		HIRE DATE	
Phone No. (Cell) **		EMAIL	

*** Please indicate at least 1 phone number*

EMAIL *optional*

	NAME (Last, First)	DOB	Social Security Number	Gender	Check Boxes for COVERAGE * Med/ Rx	Dent	Vis	Add / Term
Employee								
Spouse								
Dependent								
Dependent								
Dependent								
Dependent								
Dependent								

EMPLOYEE SIGNATURE: ______________________ DATE: ______________________

* If declining both Medical AND Dental coverage, you must complete the Health Insurance Waiver Form to be entitled to a Health Waiver Payment.

Please do not complete below - For Payroll & Insurance Use only

	Med	Dent	Vision	Notes
Employee Only	☐	☐	☐	
2 Person	☐	☐	☐	
Family	☐	☐	☐	
Retiree/Spouse	☐	☐	☐	
Decline Coverage	☐	☐	☐	