



MT. DIABLO UNIFIED SCHOOL DISTRICT  
 Office of General Counsel  
**Benefits Office**  
 (925) 682-8000 x 4152  
[benefits@mdusd.org](mailto:benefits@mdusd.org)

<b>BENEFITS USE ONLY:</b>	
<b>IFAS</b>	
<input type="checkbox"/>	ADD DEPENDENT(S)
<input type="checkbox"/>	END DEPENDENT(S)
<b>KCARES</b>	
<input type="checkbox"/>	EMPLOYEE ONLY
<input type="checkbox"/>	DEPENDENT(S)

## DENTAL & VISION -- CHANGE IN ENROLLMENT

**EMPLOYEE INFORMATION:** (Please PRINT all information)

Name: \_\_\_\_\_ ID#: \_\_\_\_\_  
Last First MI

Social Security #: \_\_\_\_\_ Phone #: \_\_\_\_\_

Email Address: \_\_\_\_\_

Position: \_\_\_\_\_ Work Site: \_\_\_\_\_

Event Date: \_\_\_\_\_ Effective Date: \_\_\_\_\_

**Action Requested:**     Adding Dependent(s)     Dropping Dependent(s)

**Reason for change:** \_\_\_\_\_

**Address for Cobra notification:** \_\_\_\_\_

### DEPENDENT INFORMATION:

List **ALL** dependents to be added or dropped.

Dependent Relationship is spouse, son, daughter, stepson, stepdaughter, adopted son, adopted daughter, domestic partner, or, if other, please specify.

Specify Add or Drop	Dependent Name	Dependent Relationship	Dependent Date of Birth	Social Security #

I understand there is no contribution required by me for coverage of myself or my dependents. I agree to continue membership in this program during employment and while the program is in force and I agree to comply with the terms of the group contract.

**Employee Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_