Fringe Benefit Consortium
6401 Linda Vista Road #505
San Diego, California 92111
(858) 292-3542
...a better way for San Diego County Schools

CONSORTIUM CUSTOM HEALTH PLAN

ELIGIBILITY FORM

DISTRICT NAME: RANCHO SANTA FE GROUP NUMBER: N/A PPO PLAN # (circle) 1 2 3

☐ Initial Enrollment ☐ Open Enrollment ☐ Change

☐ Addition ☐ Name ☐ Address
☐ Deletion ☐ COBRA ☐ AB528

Enrollee Information

Social Security No.			Effective Date:
Last:	First:	MI:	Birth Date:
Address:	City	Zip Code:	Phone No.:
Occupation:		☐ Active – Date of Employment:	
Sex: ☐ Female ☐ Male		☐ Terminated – Date of Termination:	
☐ Single ☐ Married ☐ Divorced ☐ Domestic Partner		☐ Retired – Date of Retirement:	
☐ Married/Declaration of Domestic Partner Date:		☐ Divorced/Dissolution of Domestic Partner Date:	

Dependent Information

Last Name (Spouse/Registered Domestic Partner)	First	MI	Social Security Number	Sex (M)(F)	Birthdate
(Child)					
(Child)					
(Child)					
(Child)					

DID YOU OR YOUR COVERED DEPENDENTS HAVE OTHER INSURANCE PRIOR TO YOUR DATE OF EMPLOYMENT? **YES** ☐ **NO** ☐

DO YOU OR YOUR COVERED DEPENDENTS HAVE ANY OTHER INSURANCE? **YES** ☐ **NO** ☐

Employee or Dependent	Employer	Insurance Company/ Telephone Number	Effective Date	I.D. Number

☐ I am ☐ My Spouse/Domestic Partner is Currently Enrolled in Medicare

TO BE SIGNED BY APPLICANT:

Authorization is hereby given for payroll deduction for the applicable plan cost, if any. Authorization is also given to all providers of health care services, upon request from Plan claims administrator, to furnish information concerning services provided to me or my family for claims processing.

SIGNATURE DATE