GULFPORT SCHOOL DISTRICT
ENROLLMENT / CHANGE FORM 2024

PLEASE PRINT CLEARLY

CADENCE Insurance
A Gallagher Company

Employee Information. *Please use a pen. Complete each section,* ***sign****, and return it to the HR department.*

Effective Date: _____ ***If Change Request, Reason for Change:*** _____

Employee Name (Last, First, Middle Initial)			Date of Birth	Social Security Number	
Mailing Address			Gender	Marital Status	
City	State	ZIP	Job Title	Date of Hire	Salary
Email Address			Home Phone	Cell Phone	

Dental	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
Monthly	☐ $20.15	☐ $39.56	☐ $54.17	☐ $80.23

Please check the box below if YOU ARE DECLINING Dental Coverage.

□ I understand that my dependents and I cannot enroll in this plan again until the next open enrollment, unless I have a qualifying event.

Vision	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee + Family
Monthly	☐ $7.86	☐ $15.72	☐ $17.20	☐ $26.78

Please check the box below if YOU ARE DECLINING Vision Coverage.

□ I understand that my dependents and I cannot enroll in this plan again until the next open enrollment, unless I have a qualifying event.

Family Information. *Complete one line for each family member applying for coverage, including children up to age 26. All information below is REQUIRED to enroll a dependent in the plan.*

Name (First / Middle / Last)	Benefit	Social Security Number	Date of Birth	Gender	Disabled
Spouse	□ Dental □ Vision				N/A
Child	□ Dental □ Vision				□ Yes □ No
Child	□ Dental □ Vision				□ Yes □ No
Child	□ Dental □ Vision				□ Yes □ No
Child	□ Dental □ Vision				□ Yes □ No

Authorization: I authorize any health care provider, insurance company, or other organization, institution, or person that has any information regarding my benefit eligibility or claims to release such information to the claim's administrator. A Photostat copy of this authorization shall be considered as effective and valid as the original. I understand that I have a right to receive a copy of this authorization upon request. My signature below confirms that all information and statements on this form are full, complete, and true to the best of my knowledge. I understand that any misrepresentation on this document may be cause for dismissal and may result in my coverage being void as of its effective date with no benefits payable. I understand that if I later apply for the coverage I am currently waiving, pre-existing conditions exclusions and other limitations may apply. If I have declined any of the above-listed coverages, I understand that I will not be covered for these group plan benefits for which I am eligible. I understand that I may later have to submit evidence of insurability if I want these coverages at a later date.

I also authorize the Gulfport School District to reduce my pre-tax pay to pay for the benefits in which I have elected. I further authorize the Gulfport School District to continue these pre-tax deductions until such time as I elect to change or stop such elections, subject to IRS section 125 regulations

Employee Signature _____ ***Date*** _____