Technician:		Location Site (required):

Washoe County School District
Group Benefit Programs
CHANGE FORM

PLEASE PRINT IN BLUE OR BLACK INK

Last Name	First	MI	SSN	Effective Date	Employee Id#	Date of Birth
					E000	

Address	City	State	Zip Code	Phone	Email Address

1. Status: Certified ☐ ESP ☐ Administrator ☐ Retired Certified ☐ Retired ESP ☐ Retired Administrator ☐

2. Change Coverage To: Employee/Retiree Only ☐ Plus Spouse ☐ Plus 1 Child ☐ Plus 2 Children ☐ Plus Family ☐

3. Type of Change: Deleting Dependents ☐ Adding Dependents ☐ Separation/Term ☐ Deceased ☐

Retirees Only: Delete Medical/Dental ☐ Delete Vision ☐ Delete Life Insurance ☐

4. Reason for Deleting/Adding Dependents:

Divorce ☐ Death ☐ Loss of Dependent Status ☐ Change in Spouse's Employment ☐ Marriage ☐ Birth/Adoption ☐

Domestic Partnership ☐ Loss of insurance ☐ Other (please specify) _____

5. Dependent Information (List only those dependents you are adding to or deleting from coverage. Social security number is needed for all covered dependents.)

	Last Name	First	MI	Birthday	M/F	Dependent Social Security #	Elig Docs
Spouse							☐
Child							☐
Child							☐
Child							☐
Child							☐

If deleting dependent and COBRA needs to go to a different address please list it here: _____

Employee Certification:

With my signature, I hereby declare, certify and state under penalty of perjury that the information I have provided here is true and correct, that the dependents listed above are eligible under my Employer's Dependent Benefit Criteria. Further, I understand that the information supplied, herein, may be used by my Employer in order to verify my dependent(s) for purpose of coverage, to make decisions about my coverage under my Employer's employee benefit plans and as otherwise necessary in connection with managing the organization's employee benefits plans. I understand that if the information I have provided is not true and correct, my dependent benefit coverage will be terminated, and I may be subject to disciplinary action, up to and including termination.

Employee Signature _____ Date Signed _____

BENEFITS USE ONLY:

Benefits signature:_____