Schools Insurance Group

SIG ENROLLMENT / CHANGE FORM

District Name	Employee ID#	Bargaining Unit	Date of Hire	Effective Date

I. ENROLLMENT/CHANGE REASON

☐ New Enrollment	☐ Open Enrollment	☐ Add Dependent	☐ Voluntary Termination
☐ Retirement - NEW	☐ Status Change	☐ Delete Dependent	☐ Involuntary Termination
☐ Loss of Coverage (provide HIPAA Cert)		☐ Update Address/Name	☐ Deceased

Qualifying Event: **Event Date:**

II. PLAN CHOICES

Medical Plan - *Please complete and attach carrier's enrollment form.*

Kaiser Permanente	Sutter Health Plan	Western Health Adv	Medicare
☐ Traditional HMO	☐ Traditional HMO	☐ Traditional HMO	☐ Alignment Health
☐ 1000 DHMO	☐ 1000 DHMO	☐ 1000 DHMO	☐ KPSA
☐ 2000 HDHP HMO	☐ 1750 HDHP HMO	☐ 1800 HDHP HMO	
☐ 3000 HDHP HMO	☐ 2500 HDHP HMO	☐ 2800 HDHP HMO	

Other Coverage
☐ Delta Dental
☐ Personify
☐ VSP
☐ Optum HSA (Attach App)

III. PERSONAL INFORMATION

1. Name (Last, First, M.I.)			2. Social Security Number
3. Mailing Address	City, State, Zip		4. Phone No. ( )
5. Gender ☐ Male ☐ Female	6. Date of Birth (MM/DD/YYYY) / /	7. Marital Status ☐ Single ☐ Married	8. Email Address
9. Annual Cap Amount	10. Monthly Payroll Frequency ☐10 ☐11 ☐12		11. ☐ Full Time ☐ Part Time (over 20 hrs)

IV. FAMILY INFORMATION

	Last Name, First Name, MI	Gender	Social Security Number	Date of Birth	☐ Add ☐ Delete
☐ Spouse ☐ Registered Domestic Partner		☐ M ☐ F	- -		☐ Medical ☐ Dental ☐ Vision
☐ Son ☐ Daughter			- -		☐ Medical ☐ Dental ☐ Vision
☐ Son ☐ Daughter			- -		☐ Medical ☐ Dental ☐ Vision
☐ Son ☐ Daughter			- -		☐ Medical ☐ Dental ☐ Vision
☐ Son ☐ Daughter			- -		☐ Medical ☐ Dental ☐ Vision

I authorize any payroll deduction that may be required towards the cost of this coverage. I certify that the above information is true and correct to the best of my knowledge. I understand that changes can only be made if I experience a qualifying family status change, in which case the change must be consistent with that event, or as may otherwise be provided by the group contract.

Employee Signature _____ **Date** _____

Employer Section: Must be completed by District Office Benefit Coordinator: Please initial: _____

Medical Plan Code	Dental Plan Code	Vision Plan Code	Life Amount	Health Savings Acct
☐ Add ☐ Term ☐ Chg	☐ Add ☐ Term ☐ Chg	☐ Add ☐ Term ☐ Chg	☐ Add ☐ Term ☐ Chg	☐Add ☐Term ☐Chg
Prior Plan	Prior Plan	Prior Plan	Prior Plan	
____/____/____ Effective Date	____/____/____ Effective Date	____/____/____ Effective Date	____/____/____ Effective Date	____/____/____ Effective Date