



FRINGE BENEFITS ENROLLMENT/CHANGE FORM

SCHOOL DISTRICT

GROUP NUMBER

DIVISION NUMBER

- | | | | | | |
|---------------------------------------|-------------------------------------|--|---|---|---|
| <input type="checkbox"/> NEW EMPLOYEE | <input type="checkbox"/> TERMINATED | <input type="checkbox"/> Change of Name | <input type="checkbox"/> Change Birthdate | <input type="checkbox"/> Change Effective Date | <input type="checkbox"/> Delete Spouse/Dependent(s) |
| <input type="checkbox"/> COBRA | <input type="checkbox"/> RETIRED | <input type="checkbox"/> Change of Address | <input type="checkbox"/> Change Hire Date | <input type="checkbox"/> Add Spouse/Dependent(s) | |
| | | <input type="checkbox"/> Change of Phone | <input type="checkbox"/> Change Identification Number | <input type="checkbox"/> Change Spouse/Dependent Status | |

PRINT NAME _____
OF EMPLOYEE (FIRST) (MIDDLE) (LAST) SOCIAL SECURITY # _____
() _____
ADDRESS _____ TELEPHONE # _____
ADDRESS _____ OCCUPATION _____

- | | |
|----------------------------------|-----------------------------------|
| <input type="checkbox"/> MALE | <input type="checkbox"/> WIDOWED |
| <input type="checkbox"/> FEMALE | <input type="checkbox"/> SINGLE |
| <input type="checkbox"/> MARRIED | <input type="checkbox"/> DIVORCED |

- I elect to be covered under the Fringe Benefits Plan for which I am, or may be, eligible as indicated:
(check appropriate boxes) **DENTAL BENEFITS** **VISION BENEFITS** **OPTI-VISION**
- | | | |
|---|---|---|
| <input type="checkbox"/> Employee | <input type="checkbox"/> Employee | <input type="checkbox"/> Employee |
| <input type="checkbox"/> Spouse | <input type="checkbox"/> Spouse | <input type="checkbox"/> Spouse |
| <input type="checkbox"/> Dependent Children | <input type="checkbox"/> Dependent Children | <input type="checkbox"/> Dependent Children |
- I do not want to be covered under the Fringe Benefits Plan for which I am eligible. I understand that I will have to submit satisfactory medical evidence of good health if I want this coverage after my initial period of enrollment has expired.

	MONTH	DAY	YEAR
BIRTH DATE			
EMPLOYMENT DATE			
EFFECTIVE DATE			

EMPLOYEE SIGNATURE REQUIRED _____
DATE

Please list spouse/dependents you wish to have covered under this plan.

NAME: FIRST	INITIAL	LAST	Relationship (spouse – son – daughter)	Name of College, Social Security Number and graduation date	Full-Time Student*		Birth Date		
					Yes	No	Month	Day	Year

*Please attach separate sheet with name and address of college and Social Security # of full-time student(s).
DEPENDENT TYPES – Spouse, Natural Child, Step Child, Legally Adopted Child. Is spouse employed? Yes No If yes, please provide name of spouse's employer for coordination of benefits: _____ Spouse's Social Security # _____
 Spouse Insurance Carrier _____