ST CLAIRSVILLE SCHOOLS
EMPLOYEE BENEFIT ENROLLMENT/CHANGE FORM
506-448

(PLEASE PRINT LEGIBLY OR TYPE)

EMPLOYEE'S NAME_____ SOCIAL SECURITY NUMBER_____

EMPLOYEE'S MAILING ADDRESS_____
Street

_____
City State Zip

DATE OF BIRTH	GENDER	PHONE NUMBER with area code	EMAIL ADDRESS	OCCUPATION
MO DAY YEAR	☐ FEMALE ☐ MALE			

☐ **WAIVING RIGHT TO COVERAGE:** ☐ **DENTAL COVERAGE**

NOTE: IF COVERAGE IS WAIVED, EMPLOYEE MAY NOT ENROLL UNTIL THE NEXT OPEN ENROLLMENT PERIOD OR IF HE EXPERIENCES A SPECIAL ENROLLEE EVENT.

SIGNATURE OF EMPLOYEE WAIVING COVERAGE_____ **DATE** _____

**************STOP HERE IF WAIVING COVERAGE***************

OR

☐ **APPLYING FOR COVERAGE:**

☐ DENTAL
☐ EMPLOYEE ☐ FAMILY

Check appropriate box	LIST OF ELIGIBLE DEPENDENTS First Name Last Name	RELATIONSHIP	GENDER	DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE OF MARRIAGE
☐ADDITION ☐CHANGE ☐DELETE		Spouse				
☐ADDITION ☐CHANGE ☐DELETE						
☐ADDITION ☐CHANGE ☐DELETE						
☐ADDITION ☐CHANGE ☐DELETE						
☐ADDITION ☐CHANGE ☐DELETE						

NOTE: If coverage includes dependents, you **MUST** attach proof of marriage, birth, etc. Give last name of dependent if other than yours.

IS YOUR SPOUSE EMPLOYED? ☐YES ☐NO **IF YES, PLEASE INDICATE THE NAME OF THE EMPLOYER**_____

DO YOU, YOUR SPOUSE OR DEPENDENTS, INCLUDING DEPENDENTS AGE 19 - 26, HAVE OTHER GROUP HEALTH PLAN COVERAGE (THROUGH THEIR EMPLOYER, MEDICARE OR ANOTHER PLAN)? ☐YES ☐NO

IF YES, LIST NAME/ADDRESS OF INSURANCE COMPANY_____**GROUP#**_____
TYPE OF COVERAGE ☐DENTAL
ALL INDIVIDUALS COVERED UNDER THIS COVERAGE _____

DO ALL COVERED DEPENDENTS LISTED ABOVE LIVE AT THE SAME ADDRESS AS ABOVE? ☐YES ☐NO
IF NO, PLEASE PROVIDE DEPENDENT NAME AND ADDRESS _____

I REQUEST COVERAGE UNDER MY EMPLOYER'S BENEFIT PLAN. I AM ACTIVELY AT WORK THE MINIMUM NUMBER OF HOURS REQUIRED TO PARTICIPATE IN THE PLAN.

I HEREBY CERTIFY THAT THE PRECEDING STATEMENTS ARE ACCURATE. I AUTHORIZE ANY PERSON OR INSTITUTION RENDERING CARE, OR ANY PERSON OR ORGANIZATION (INCLUDING MY EMPLOYER) IN POSSESSION OF INFORMATION CONCERNING INSURANCE OR OTHER BENEFITS COVERING ME OR MY DEPENDENTS TO FURNISH TO, OR RECEIVE FROM, SELF-FUNDED PLANS, INC. OR ITS REPRESENTATIVE, FULL INFORMATION REGARDING SUCH CARE OR OTHER BENEFIT INFORMATION. THIS AUTHORIZATION SHALL REMAIN IN EFFECT FOR AS LONG AS MY DEPENDENTS AND I ARE ELIGIBLE TO RECEIVE BENEFITS UNDER THE PLAN. A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.

ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY MISREPRESENTATION OR ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW AND MAY BE SUBJECT TO CIVIIL PENALTIES.

SIGNATURE OF EMPLOYEE _____ **DATE** _____

TO BE COMPLETED BY EMPLOYER

DATE OF EMPLOYMENT _____ ☐ **CERTIFIED** ☐ **CLASSIFIED/ADMIN** **DENTAL EFFECTIVE DATE** _____
DATE ENROLLMENT FORM WAS RECEIVED BY EMPLOYER _____

REASON FOR ENROLLMENT/CHANGE: ☐ NEW HIRE ☐ REHIRE ☐ OPEN ENROLLMENT ☐ CHANGE OF ADDRESS
☐ NAME CHANGE ☐ MARRIAGE ☐ ADDITION OF DEPENDENT ☐ LOSS OF OTHER COVERAGE **(ATTACH PROOF OF LOSS OF COVERAGE)**
☐ OTHER (please describe) _____ ☐ DELETION OF DEPENDENT (COMPLETE DEP TERM OF COVERAGE FORM)

01/24.25