L CENTRO ELEMENTARY SCHOOL DISTRICT

***Effective Date**
for new enrollment (mm/dd/yy)
/ /

ENROLLMENT FORM

A ENROLLEE (Complete this section for new enrollment or change of status)

* If left blank coverage will be effective on the 1st of the month following receipt of this form.

Employee Name (Last) (First) (Middle Initial)	Social Security Number	Gender ☐ M ☐ F	Date of Birth (mm/dd/yy) / /	*Date of hire (mm/dd/yy) / /

Street Address

City | State | Zip

Phone Number ( )

Marital Status:
- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Legally Separated

Employee Status:
- ☐ Certificated
- ☐ Classified
- ☐ Management
- ☐ Retired
- ☐ Full-Time
- ☐ Part-Time
- ☐ COBRA

B ACTION

☐ New Enrollment

CLASSIFICATION

☐ Employee ☐ Emp + Child(ren)
☐ Emp + Spouse ☐ Emp + Family

COVERAGE ELECTED

DENTAL & VISION: ☐ Buy-Up (01) ☐ Basic (02)

OTHER COVERAGE FOR COB PURPOSES

Does your spouse have coverage? ☐ Yes ☐ No

If yes, who is covered?
☐ Self ☐ Spouse ☐ Dependent Child(ren)

C DEPENDENTS (Last name required if different from employee's. Dependents not listed below will not be enrolled for coverage.)

Spouse's Name	Date of Birth (MM/DD/YY) / /	Gender ☐ M ☐ F	Social Security Number	Is your spouse employed by school within the El Centro? ☐ Yes ☐ No	
Dependent's Name	Date of Birth (MM/DD/YY) / /	Gender ☐ M ☐ F	Social Security Number	Relationship ☐ Son ☐ Daughter Other ____	Disabled ☐ Yes ☐ No
Dependent's Name	Date of Birth (MM/DD/YY) / /	Gender ☐ M ☐ F	Social Security Number	Relationship ☐ Son ☐ Daughter Other ____	Disabled ☐ Yes ☐ No
Dependent's Name	Date of Birth (MM/DD/YY) / /	Gender ☐ M ☐ F	Social Security Number	Relationship ☐ Son ☐ Daughter Other ____	Disabled ☐ Yes ☐ No
Dependent's Name	Date of Birth (MM/DD/YY) / /	Gender ☐ M ☐ F	Social Security Number	Relationship ☐ Son ☐ Daughter Other ____	Disabled ☐ Yes ☐ No

D ACCEPTANCE OF EMPLOYEE AND/OR DEPENDENT INSURANCE

I certify that I am engaged in regular FULL-TIME EMPLOYEMENT WITH WAGES SUBJECT TO WITHHOLDING at the above named School District. I authorize my employer to make deductions, if required, from my earnings necessary to provide my contribution for this coverage.

Your Signature (in ink) ____________________ Date ____________

E REFUSAL OF EMPLOYEE AND/OR DEPENDENT COVERAGE

I have been given an opportunity to apply for group dental and vision with the El Centro Elementary School District (ECESD) and I have declined to apply for the following coverage(s). If dependent coverage is declined due to group coverage elsewhere, please note carrier and policy number below.

☐ Refusing All Employee benefits provided under the plan. ☐ Refusing All Dependent benefits provided under the plan.

Reason(s) for declining coverage(s): ____

Other Coverage: ____
Carrier Policy # Insured's Name

I understand that if I desire to apply for coverage for myself and/or my dependents at a later date, I will have to furnish, at my own expense, evidence of insurability which must be approved by the Plan before becoming insured.

Your Signature (in ink) ____________________ Date ____________

Rev. 10/18