IMPERIAL VALLEY SCHOOLS
JOINT POWERS AUTHORITY (IVSJPA)

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

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	Date of Birth (mm/dd/yy)	*Date of hire (mm/dd/yy)
		M ☐ FE ☐	/ /	/ /

Street Address	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated	Employee Status: ☐ Certificated ☐ Classified ☐ Management ☐ Retired ☐ Full-Time ☐ Part-Time ☐ COBRA
City State Zip		
Phone Number ( )		

B ACTION	CLASSIFICATION	COVERAGE ELECTED	OTHER COVERAGE FOR COB PURPOSES
☐ New Enrollment	☐ Employee ☐ Emp + Child(ren) ☐ Emp + Spouse ☐ Emp + Family	DENTAL & VISION: ☐ Premier (01) ☐ Standard (02)	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.)

Name	Date of Birth (MM/DD/YY)	Gender	Social Security Number		
Spouse's Name	/ /	☐ M ☐ F		Is your spouse employed by an IVSJPA school district? ☐ Yes ☐ No	
Dependent's Name	/ /	☐ M ☐ F		Relationship ☐ Son ☐ Daughter Other ____	Disabled ☐ Yes ☐ No
Dependent's Name	/ /	☐ M ☐ F		Relationship ☐ Son ☐ Daughter Other ____	Disabled ☐ Yes ☐ No
Dependent's Name	/ /	☐ M ☐ F		Relationship ☐ Son ☐ Daughter Other ____	Disabled ☐ Yes ☐ No
Dependent's Name	/ /	☐ M ☐ F		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 Imperial Valley Schools Joint Powers Authority (IVSJPA) 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 ____________

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