

Medical Benefits - CHANGE / TERMINATION FORM



EMPLOYEE INFORMATION			
Last Name	First Name	Initial	Social Security Number

REASON FOR REQUESTED CHANGE	
Benefits Change Effective Date:	/ /
1. Addition of Dependent Coverage <input type="checkbox"/> Spouse <input type="checkbox"/> Natural Child <input type="checkbox"/> Adopted Child <input type="checkbox"/> Stepchild	Date of Marriage, Birth, Adoption / /
2. Termination of ALL Dependent Coverage - Reason	Effective Date / /
3. Termination of Named Dependent(s) <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren) Name(s) _____ Reason(s) _____	Effective Date / /
4. Change Plan Option (Open Enrollment Only) From: _____ To: _____	Effective Date / /
5. Change Status <input type="checkbox"/> Retiree <input type="checkbox"/> COBRA	Effective Date / /
6. Termination of Life Insurance <input type="checkbox"/> Basic Life <input type="checkbox"/> AD&D <input type="checkbox"/> Dependent Life	Effective Date / /
7. Reinstate Coverage <input type="checkbox"/> ALL <input type="checkbox"/> Employee <input type="checkbox"/> Dependent	Effective Date / /
8. Cancel ALL Coverage <input type="checkbox"/> Termination of Employment <input type="checkbox"/> Leave/Lay Off	Effective Date / /
9. Other Changes <input type="checkbox"/> Name <input type="checkbox"/> Address	
Name _____	
Address _____	
City _____ Zip _____ Country _____	

EMPLOYEE ELECTION	COVERAGE SELECTED
<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + Child(ren) <input type="checkbox"/> Employee + Family	<input type="checkbox"/> Comprehensive Option <input type="checkbox"/> Basic Option <input type="checkbox"/> Bronze Option
NETWORK SELECTED	
Blue Shield	

EMPLOYER USE ONLY	
Name of EMPLOYER (District)	San Pasqual Valley Unified School District
Employment Date _____	
Employment Status <input type="checkbox"/> Full Time <input type="checkbox"/> Retiree <input type="checkbox"/> COBRA (attach form) <input type="checkbox"/> Part Time <input type="checkbox"/> Disabled <input type="checkbox"/> ICSIS #	

HUB OFFICE USE ONLY	
Date Received: _____	Initials
Date Processed: _____	
VB: _____ DB: _____ DHS: _____ ADJ: _____	Initials

EMPLOYEE MUST SIGN HERE	
Employee Signature _____	Date _____
X	

Use this space to list eligible dependent changes. Last name required if different from employee's				
Spouse's Name	Date of Birth / /	Sex <input type="checkbox"/> M <input type="checkbox"/> F	SSN	
Dependent's Name	Date of Birth / /	Sex <input type="checkbox"/> M <input type="checkbox"/> F	SSN	Relationship <input type="checkbox"/> Son <input type="checkbox"/> Daughter Other
Dependent's Name	Date of Birth / /	Sex <input type="checkbox"/> M <input type="checkbox"/> F	SSN	Relationship <input type="checkbox"/> Son <input type="checkbox"/> Daughter Other