☐ New Enrollee
☐ Change of Enrollment

Enrollment / Change Card

Please type or print in ink. ***Employer – Complete all shaded areas at the top of the card.*** ***Employee – Complete all shaded areas.***

Name or employer **DELTA COUNTY SCHOOL DISTRICT 50J**	Date of Full Time Eligibility	Salary	Effective Date (Required)
1. Employee's Name (last, first, middle initial)	2. Social Security #		3.Date of Birth
4. Employee's mailing address Street City State Zip			5. Male ☐ Female ☐
6. Beneficiary's name	7. Relationship to you		

8.	Standard Medical/Dental	LIFE	CEBT VISION Plan B
	4		
Employee Only	☐	☐	☐
Employee & Spouse	☐	☐	☐
Employee & Child	☐	☐	☐
Employee & Children	☐	☐	☐
Family	☐	☐	☐
MPA (Only)			**W**

9. Do you want dependent coverage? yes ☐ no ☐ If yes, complete below and provide proof of legal dependency such as Certificates of birth, marriage, common law, civil union and adoption.

Last, First	Social Security Number (Required)	Date of Birth	Gender	Enrolled in Medicare?
1 .Spouse				Y / N
2. Dependent Child				Y / N
3. Dependent Child				Y / N
4. Dependent Child				Y / N
5. Dependent Child				Y / N
6. Dependent Child				Y / N

10. PLEASE CHECK ONE:

Add Spouse ☐ Effective Date _____ Marriage ☐ Drop Spouse ☐ Effective Date _____ Divorce ☐

Add Dependent(s) ☐ Drop Dependent(s) ☐ Beneficiary Change ☐ Name Change ☐ Address Change ☐

Unless otherwise provided herein, if two or more beneficiaries are named, the proceeds shall be paid in equal shares to the named beneficiaries if surviving the insured, or the survivors. If no beneficiary survives, payment should be made in accordance with the terms of the policy.

11. Employee's signature _____ Home Phone # _____ 12. Date Signed _____

FOR MPA USE ONLY				**COV. TYPE** (20) e s c f					
BENEFIT CLASSES (four digits)				**VOLUMES** * (If applicable, enter 1000 for DEP and/or DEP VLIF)					
EFFECTIVE DATE	**EE** (23)	**SP** (23)	**CH** (23)	**Enrollee** (01)	***DEP** (Member 03)	**Supplemental** (04)	**Short Term**	**Long Term**	***DEP VLIF**

05/2015