Canon-McMillan School District

Healthcare Enrollment/Change Form

SECTION I - TO BE COMPLETED BY EMPLOYEE/RETIREE

Use this form to select/change a medical, dental and/or vision plan and coverage level.

Reason for completing form: ☐ New Hire ☐ Current employee enrolling ☐ Change ☐ Termination

Type of Change: ☐ Name ☐ Address ☐ Add spouse/dependent ☐ Remove spouse/dependent

Hire Date: | **Benefit Type:** ☐ Medical ☐ Dental ☐ Vision

Name (First, Middle, Last)	Social Security Number	Date of Birth	Male/Female	Add or Drop
Employee/Retiree			☐M ☐F	
Spouse			☐M ☐F	
Dep			☐M ☐F	
Dep			☐M ☐F	
Dep			☐M ☐F	

Street Address

City | State | ZIP Code

SECTION II - TO BE COMPLETED BY EMPLOYEE/RETIREE: ELECTION OF BENEFITS

Election(s)			Coverage Level/Tier				
Medical	☐ EPO	☐ PPO	☐ EE	☐ EE + CH	☐ EE + CHN	☐ EE + SP	☐ FAM
Dental			☐ EE	☐ FAM			
Vision			☐ EE	☐ FAM			

Return this completed form within 30 days of your date of hire, probationary period end date, or qualifying life event along with any required documentation (ie. marriage certificate, birth certificate, etc.) Refer to the Instructions for Benefits Elections/Changes to determine what documents you need to provide. Your benefits will not be updated until all documentation is received.

I certify that the above information is true and correct. By not enrolling in benefits within 30 days of hire (or end of probationary period) or within 30 days of a qualifying life event, I will be unable to enroll or make changes again until the next annual Open Enrollment period.

Employee/Retiree Signature: | **Date:**

SECTION III - TO BE COMPLETED BY SCHOOL DISTRICT

Effective Date of Change: **Date Section I Recieved:**

Qualifying Life Event

☐ Act 110/Act 43 Eligible	☐ Divorce	☐ Newborn	☐ Termination
☐ Adoption	☐ Legal Guardianship	☐ Over Age Dependent	☐ COBRA - ☐ Med ☐ Dental ☐ Vision
☐ Court Ordered	☐ Marriage	☐ Resignation - Voluntary	
☐ Death	☐ Medicare Entitlement	☐ Retirement	

Signature of District Representative: | Date: