San Jose Unified School District

GROUP INSURANCE ENROLLMENT FORM

CLAIMS CANNOT BE PROCESSED UNLESS YOUR ENROLLMENT CARD IS ON FILE (Please Print)

(For Administrator Use Only)

Effective Date	*Life Amt $50K*	*# Covered*	*Dependent Documentation*	*O/E*	*New Hire*

Employee Name (Last, First, MI)	Employee Soc. Sec. #	Employee ID # Date of Birth
Home Address	City, State, Zip	Classified_____ Certificated_____
Work Location/Work Phone	# of hours worked per week/FTE /	Position

Please indicate Union: ***AFSCME_____ AFT_____ CSEA_____ SJTA_____ TRADES_____ OR SJAA_____*** **Board of Education_____**

Employment Status: Active_____ Retired_____ Disabled_____ Leave of Absence_____ Dependent Survivor_____

☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated Date of Marriage _____ Children ☐ Yes ☐ No
Month/Day/Year

ENROLLMENT FOR INSURANCE (Please choose appropriate plan)

Choose one Medical Plan:

☐ **FOUNDATION (or)** ☐ **KAISER** (Also complete separate Kaiser enrollment form)

☐ **DENTAL DPPO** ☐ **LIFE** (Complete Beneficiary Information Section) ☐ **DEPENDENT LIFE**

☐ **DENTAL DHMO** ☐ **VSP** (Vision)

Change the Following:

Add Dependent(s) ☐	Delete Dependent(s) ☐	New Plan ☐
Switch to Foundation ☐	Switch to Kaiser ☐	Cancel Plan ☐

Do you have other medical insurance coverage? _____Yes _____No (if yes, please indicate plan)
(i.e. Medicare, Medi-Cal, Other group or individual plan, etc.)_____

Dependent Name (Last, First, MI)	Relationship*	Gender	Date of Birth	Soc. Sec. #	Comments
	(S) (C) (DP)	(Male) (Female)			
	(S) (C) (DP)	(Male) (Female)			
	(S) (C) (DP)	(Male) (Female)			
	(S) (C) (DP)	(Male) (Female)			

Required Documents for Dependents: (Marriage Certificate or 1040 Tax Return, Birth Certificate, Social Security Card, Domestic Partner Form)

***Relationship = (S) Spouse (C) Child (DP) Domestic Partner**

CERTIFICATION

I hereby request coverage for the Group Insurance for which I am or may become eligible; (2) authorize my employer to make the necessary deductions for the contributions, if any, on a pre-tax basis; and (3) currently work the number of hours per week required to be eligible for insurance. I understand no coverage will be effective until I am actively at work at my regular place of employment on or after the effective date of the Master Policy. I also understand that I may not change or cancel these elections until Open Enrollment, unless I experience a qualified status change event (as defined by the Internal Revenue Code) consistent with the requested change and submit the completed paperwork to the Benefits Department within 31 days of the event. If at any time I participate in unpaid leave under the Family & Medical Leave Act (FMLA) or California Family Rights Act (CFRA), I will be billed for any unpaid contributions. I understand if my FTE drops below 75% I will no longer be eligible and my coverage will be terminated. I agree to notify the Benefits Department if one of my listed dependents ceases to qualify as an eligible dependent or if the address of one of my dependents changed. Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer submits an application or files a claim containing false or deceptive statement is guilty of insurance fraud and will be subject to the termination of their employment by the District. You must sign the form certifying under penalty of perjury under the laws of the state of California that the foregoing is true and correct based upon personal knowledge.

_____ _____
Employee Signature Date

Note: Dual Coverage is not permitted.

_____ _____
Human Resources/Benefits Signature Date

For Benefits Use Only: