

Employer: Muncie Community Schools

EFFECTIVE DATE

JOB TITLE/WORK LOCATION

**EMPLOYEE INFORMATION**

LAST FIRST MI MALE  FEMALE  SINGLE  MARRIED

SOCIAL SECURITY NUMBER

DATE OF BIRTH

CONTACT NUMBER

ADDRESS

**MEDICAL**  EMPLOYEE ONLY  EMPLOYEE+1  FAMILY  NO COVERAGE

**DENTAL**  EMPLOYEE ONLY  EMPLOYEE+SPOUSE  MEMBER+CHILD(REN)  FAMILY  NO COVERAGE

**VISION**  EMPLOYEE ONLY  EMPLOYEE+1  FAMILY  NO COVERAGE

**CHANGE OF DEPENDENT STATUS**

NAME	RELATIONSHIP	SOC SEC NUMBER	DATE OF BIRTH	SEX	MEDICAL (circle one)	DENTAL (circle one)	VISION (circle one)
	<input type="checkbox"/> spouse			<input type="checkbox"/> M <input type="checkbox"/> F	Add/ Drop/ Continue	Add/ Drop/ Continue	Add/ Drop/ Continue
	<input type="checkbox"/> child <input type="checkbox"/> stepchild			<input type="checkbox"/> M <input type="checkbox"/> F	Add/ Drop/ Continue	Add/ Drop/ Continue	Add/ Drop/ Continue
	<input type="checkbox"/> child <input type="checkbox"/> stepchild			<input type="checkbox"/> M <input type="checkbox"/> F	Add/ Drop/ Continue	Add/ Drop/ Continue	Add/ Drop/ Continue
	<input type="checkbox"/> child <input type="checkbox"/> stepchild			<input type="checkbox"/> M <input type="checkbox"/> F	Add/ Drop/ Continue	Add/ Drop/ Continue	Add/ Drop/ Continue
	<input type="checkbox"/> child <input type="checkbox"/> stepchild			<input type="checkbox"/> M <input type="checkbox"/> F	Add/ Drop/ Continue	Add/ Drop/ Continue	Add/ Drop/ Continue
	<input type="checkbox"/> child <input type="checkbox"/> stepchild			<input type="checkbox"/> M <input type="checkbox"/> F	Add/ Drop/ Continue	Add/ Drop/ Continue	Add/ Drop/ Continue

**OTHER INSURANCE INFORMATION**

Do you or any of your family members have other Group Health Insurance including Medicare? Yes  No

If "Yes" to Medicare, please check all coverages that are applicable: Part A  Part B

If YES, what types of benefits are covered? MEDICAL  RX  DENTAL  VISION

If YES: Name of Insured Person:

Birthdate of Insured Person:

Covered Dependents:

Insurance Company Name:

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 a false or deceptive statement is guilty of insurance fraud.

Employee Signature

Date

To be completed by Employer:

- Change Dependent Status \_\_\_\_\_
- Name Change – Formerly \_\_\_\_\_
- Cancellation \_\_\_\_\_
- Date Change Occurred \_\_\_\_\_