KIDZ PLAN ENROLLMENT/CHANGE FORM

PATTONVILLE SCHOOL DISTRICT

SECTION A

☐ OPEN ENROLL ☐ CHANGE ☐ NEW ENROLL ☐ REINSTATE

EFFECTIVE DATE OF ADD/CHANGE/CANCELLATION (MM/DD/CCYY)

SCHOOL NAME: **PATTONVILLE SCHOOL DISTRICT**

ANTHEM GROUP NO. **0040052777**

DATE OF HIRE (MM/DD/CCYY)

TYPE OF CHANGE: _____

☐ Add Dependent(s)* Date:_____
☐ Cancel Employee Date:_____
☐ Cancel Dependent(s)* Date:_____
*List Names in Section B

☐ Marriage Date:_____ ☐ Name Change ☐ Family Security Benefit/Surviving Spouse
☐ Newborn Date of Birth:_____ ☐ Transfer to Cobra ☐ Retirement Date: _____
☐ Part-time to Full-time Status ☐18 mo. ☐29 mo. ☐36 mo. ☐ Employee Terminated
☐ Other (Please Specify): _____

SECTION B

EMPLOYEE NAME (Last)	(First)	(MI)	SOCIAL SECURITY NO	GENDER	MARITAL STATUS

EMPLOYEE DATE OF BIRTH (MM/DD/CCYY)	HOME PHONE ( )	WORK PHONE ( )	EMPLOYEE E-MAIL ADDRESS	POSITION/OCCUPATION

ADDRESS (Street)	(City)	(State)	(Zip Code)

I WOULD LIKE COVERAGE FOR ME AND MY DEPENDENTS (Specify last name if different from yours) Last Name / First Name / MI		DEPENDENT SOCIAL SECURITY NO.	DATE OF BIRTH MM DD CCYY	GENDER	COVERAGE	CHECK ONE
Employee				☐ M ☐ F	☐ Medical	☐ Add ☐ Cancel
Spouse				☐ M ☐ F	☐ Medical	☐ Add ☐ Cancel
Dependent*	Relationship:			☐ M ☐ F	☐ Medical	☐ Add ☐ Cancel
Dependent*	Relationship:			☐ M ☐ F	☐ Medical	☐ Add ☐ Cancel
Dependent*	Relationship:			☐ M ☐ F	☐ Medical	☐ Add ☐ Cancel

SECTION C

Medical Options

☐ **Kidz Plan** ☐ Decline Coverage

SECTION D

OTHER HEALTH CARE COVERAGE :Do you or your dependents have other health insurance under a qroup plan, HMO, or Medicare? ☐ Yes ☐ No If yes, please provide the following:

NAME OF PERSON COVERED	SOCIAL SECURITY NO.		
		☐ Medicare Part A	Effective Date _____
		☐ Medicare Part B	Effective Date _____
		☐ Medicaid	Effective Date _____
		☐ Other Insurance Carrier	Effective Date

SECTION E

SIGNATURE - The information provided above is true and correct to the best of my knowledge.

Employee's Signature / Date_____ Employer's Signature / Date_____