☐ Enrollment

☐ Change

GARDEN GROVE UNIFIED SCHOOL DISTRICT
HEALTH BENEFITS ENROLLMENT & CHANGE FORM

EMP #:_____

1. SELECTED MEDICAL COVERAGE—choose ONE

☐ **PPO**—Preferred Provider Organization ☐ **HMO** (Additional HMO Enrollment Form Required)

☐ **EPO**—Exclusive Provider Organization

Plan Change From _____ **To**_____

2. SELECTED DENTAL COVERAGE—choose ONE

☐ **Self-Insured Dental Plan PPO** ☐ **United Concordia HMO** (Additional HMO Enrollment Form Required)

Plan Change From _____ **To**_____

3. ☐ VSP Vision Plan (No Card)

Office use only: ☐ E&A ☐ HR ☐ S

MEDICAL CODE	DENTAL CODE	FROM DIV: / DISTRIBUTION
		ACCT ☐ UC ☐
		ANTHEM ☐ IGOE ☐
		HNAS ☐ FILE ☐
		GUARD ☐ PERS ☐
TYPE	CAT	EFF DATE
B. U.	DIVISION NO.	LIFE

4. PERSONAL INFORMATION

☐ M ☐ F	LAST NAME	FIRST NAME	M.I.	DATE OF HIRE
STREET ADDRESS		CITY	STATE	ZIP
TELEPHONE NO. WITH AREA CODE	WORKSITE LOCATION	SOCIAL SECURITY NUMBER	DATE OF BIRTH	

5. QUALIFYING EVENT—REASON FOR ENROLLMENT / CHANGE

DATE OF EVENT: _____

☐ NEW HIRE ☐ RETURN TO WORK ☐ RETIREMENT
☐ MARRIAGE ☐ DOMESTIC PARTNERSHIP ☐ BIRTH / ADOPTION (circle)
☐ OPEN ENROLLMENT ☐ CHANGE OF OTHER COVERAGE ☐ NAME CHANGE
☐ CHANGE OF ADDRESS ☐ DIVORCE / LEGAL SEPARATION ☐ OTHER:_____

FORMER NAME (name change only)

LAST NAME

FIRST NAME

6. DEPENDENT INFORMATION

	M F	LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY NUMBER	DATE OF BIRTH	
Spouse / DP	☐ ☐						☐ NO CHG ☐ ADD ☐ DEL
Child	☐ ☐						☐ NO CHG ☐ ADD ☐ DEL
Child	☐ ☐						☐ NO CHG ☐ ADD ☐ DEL
Child	☐ ☐						☐ NO CHG ☐ ADD ☐ DEL
Child	☐ ☐						☐ NO CHG ☐ ADD ☐ DEL

7. OTHER INSURANCE COVERAGE — DO YOU OR ANYONE ON YOUR PLAN HAVE:

Other MEDICAL Insurance? ☐ YES ☐ NO
Start Date _____ End Date_____
Name of Insurance _____
Subscriber Name _____
Subscriber ID#_____ DOB _____
Who is covered (list) _____

Other DENTAL Insurance? ☐ YES ☐ NO
Start Date _____ End Date_____
Name of Insurance _____
Subscriber Name _____
Subscriber ID#_____ DOB _____
Who is covered (list) _____

MEDICARE A or B ☐ NO ☐ YES—Please attach a copy of card(s) **MEDICARE D** ☐ NO ☐ YES— Who is covered _____ Effective Date _____

I agree that the above information is true and correct. I agree to advise the Insurance Department, in writing, of any change(s) affecting my coverage.

I hereby certify that I have a valid Certificate of Marriage or Declaration of Domestic Partnership recognized by the State of California. It is further understood that I am required to present said Certificate as proof of dependent eligibility.

I understand the participating eligible dependent child(ren) listed above must be Natural Born, Legally Adopted or placed by court order under the eligible Parent or Legal Guardian. It is further understood that I am required to present proof of dependent status.

I agree that enrollment, eligibility, coverage, and benefits in my health plan are subject to applicable policies and requirements and to all terms of the applicable contract for my health plan.

I agree to reimburse the Plan for any overpayment made to me or on my behalf due to error.

SIGNATURE _____ **DATE** _____