☐ **New Enrollee/ Open Enrollment** ☐ **Re-Hire** ☐ **Change** ☐ **Retirement or Termination**
☐ **Qualifying Life Event (must provide appropriate documentation)**

General Information

1) Name of Account

COLONIAL BEACH PUBLIC SCHOOLS

2) Employee Name Last	First	MI

3) Social Security #	**4) Annual Salary**	**5) DOB**	**6) Gender** M F

7) Mailing Address Street	City	State	Zip	**8) Home Phone**

9) If Change of Status, Please specify: Add Terminate Change Correction Reason: Date:	**10) Hire Date**	**11) Hrs. Wkd/Wk**	**12) Marital Status** Married Divorced Single

Dependents (Complete for all Dependent Coverage)

Please check the type of coverage desired for each dependent listed

Name	*Relationship*	*M/F*	*DOB*	*Social Security #*	*Health*	*Dental*	*Vision*
1							
2							
3							
4							
5							
6							
7							

HEALTH	**ANTHEM**	Choose One: HEALTHKEEPERS HSA PLAN HEALTHKEEPERS POS PLAN Both - Virginia Network KEYCARE PLAN National Network

I wish to elect coverage for: Employee Only (Self) Employee + Spouse
Employee + 1 Child Employee + Children Employee + Family

HSA Plan Only:
HSA Election: I would like to deduct $_____each pay period to be transferred to a Health Savings Account_

Was the **employee** enrolled in a prior health plan?	NO	YES	List # of months:
Were the **dependents** enrolled in a prior health plan?	NO	YES	List # of months:

Previous Carrier Name: Policy Number:
Effective Date: Termination Date:

PRIMARY CARE PHYSICIAN

Anthem PCP Name (please provide first and last name):	Anthem PCP ID #:
PCP Address:	Current Patient? Yes No

I wish to decline/waive coverage:
Reason:

HEALTH EFFECTIVE DATE:	**HEALTH TERMINATION DATE:**

DENTAL	**ANTHEM**	

I wish to elect coverage for: Employee Only (Self) | Employee + Spouse | Employee + 1 Child | Employee + Child(ren) | Employee + Family

Was the **employee** enrolled in a prior dental plan?	NO	YES	List # of months:
Were the **dependents** enrolled in a prior dental plan?	NO	YES	List # of months:

I wish to decline/waive coverage:
Reason:

DENTAL EFFECTIVE DATE:	**DENTAL TERMINATION DATE:**

VISION	**SUPERIOR**	Policy Number 36500

I wish to elect coverage for: Employee Only (Self) | Employee + Spouse | Employee + Child(ren) | Employee + Family

I wish to decline/waive coverage:
Reason:

VISION EFFECTIVE DATE:	**VISION TERMINATION DATE:**

Flexible Spending can only be enrolled during your annual Open Enrollment.

Certification & Authorization

I certify that all information on this form is true and complete to the best of my knowledge and belief. I understand that this insurance is subject to all of the terms of the Plan of Insurance contained in the group policy and summarized in the announcement material provide me and the certificate issued me.

I understand that the effective date of insurance for myself or for any of my dependents is subject to being actively at work on that date and that the effective date of insurance for any of my dependents is also subject to the dependent health condition requirements of the Plan. Further, I understand that any insurance subject to evidence of good health or medical information will not become effective until the above companies give their written consent.

I understand that, in the event I fail to sign this form within 31 days of the effective date of eligibility or that for any reason the insurance companies do not receive notice of the Enrollment/Change Request within a reasonable time following the event, my and my dependents' eligibility may be affected.

I request my employer to arrange for the issuance of the coverage listed above for which I am or may become eligible and authorize deductions of the required contributions from my earnings.

Employee Signature: **Date Signed:**