SUPPORT STAFF HEALTH INSURANCE ENROLLMENT FORM

Were you hired as a CCSD School Police Officer? *

Please select one.

- [ ] Yes
- [ ] No

Today's Date *

SECTION A – EMPLOYEE INFORMATION

Full Name *

First Name Last Name

Social Security Number *

XXX-XX-XXXX or XXXXXX

Date of Birth *

Date of Birth

Hire Date *

Gender *

Personal Phone Number *

Phone Ext

Address *

Street City

Zip Code

Are you married to or Domestic Partners with another CCSD employee? *

Name and social security number of CCSD spouse or domestic partner:

Deduct my medical premiums “pre-taxed” (Section 125 POP Plan):* *

*Please note: If you add your Domestic Partner to your plan, premiums for you, your Domestic Partner, and any other Eligible Dependents cannot be taken from your paycheck on a pre-tax basis through the CCSD Section 125 Premium Only Plan.

Deduct my medical premiums “pre-taxed” (Section 125 POP Plan):* *

*Please note: If you add your Domestic Partner to your plan, premiums for you, your Domestic Partner, and any other Eligible Dependents cannot be taken from your paycheck on a pre-tax basis through the CCSD Section 125 Premium Only Plan.

SECTION B - MEDICAL PLAN SELECTION

Choose one option. *

Choices below include Vision and Dental coverage.

**If you enroll in the HPN/Sierra – HMO plan, you must contact HPN to select a Primary Care Physician

SECTION C – DEPENDENT COVERAGE

	Name	Social Security Number	Date of Birth	Gender (M/F)
Spouse				
Domestic Partner				

Child				
Child				
Child				
Child				

PLEASE READ CAREFULLY BEFORE SUBMITTING FORM

WARNING: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. *

☐ I have read the foregoing statements and answers and declare them to be true and complete to the best of my knowledge and belief. I agree that they shall be used as the basis of acceptance for coverage of me and my Eligible Family Member(s) (if any). I realize that any material misrepresentation or omission regarding eligibility for coverage may result in rescission of my coverage.