

GALENA PARK ISD MEDICAL/DENTAL ENROLLMENT/CHANGE FORM

Employee Information

Employee Name _____ Employee SS# _____

Street Address _____

City State Zip

Phone Number _____

Please Check the box for all that applies:

- Address Change**
 Name Change
 Qualifying Event (Attach Documentation)

Medical Enrollment Please check all that apply:

- Enroll Plan PPO
 Active Care 1
 Active Care 2
 Active Care 3
 Add/Remove Dependent
 Cancel Plan
 Waive

Dental Enrollment Please check all that apply:

- Enroll Plan DHMO
 Add/Remove Dependent
 Cancel Plan
 Waive
 Enroll Plan PPO

Vision Enrollment Please check all that apply:

- Add/Remove Dependent
 Cancel Plan

(A)dd (C)hange (R)emove	First Name MI Last Name	Sex M F	Birthdate mm/dd/yy	Social Security Number	Medical	Dental	Vision
	E				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	S				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	C				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	C				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	C				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	C				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	C				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

E-Employee S-Spouse C-Child

Cancellation of Optional Benefits:

- Employee Supplemental Life Insurance
 Spouse Supplemental Life Insurance
 Child Supplemental Life Insurance
 Disability

EMPLOYEE SIGNATURE _____ DATE _____

For Office Use Only

Effective Date: _____

Type of Qualifying event: _____

Processed: _____