CIRCLEVILLE CITY SCHOOLS
INSURANCE ENROLLMENT FORM

I. General Information

NAME: _____ SOCIAL SECURITY: _____

DATE OF BIRTH: _____ DATE OF HIRE: _____ MARITAL STATUS: _____

ADDRESS: _____

NUMBER OF DEPENDENTS: _____ EFFECTIVE DATE: _____

II. Medical Election

Options		
Employee Only	☐	
Employee + Family	☐	
Waive Coverage	☐	

III. Dental Election

Options	
Employee Only	☐
Employee + Family	☐
Waive Coverage	☐

IV. Vision Election

Options	
Employee Only	☐
Employee + Family	☐
Waive Coverage	☐

V. Covered Dependents (If same as last year please indicate that in the name field and no other info is needed)

Name	Social Security Number	Gender	Relationship	Date of Birth	Coverage
			☐ Spouse ☐ Child		☐ Medical ☐ Dental ☐ Vision
			☐ Spouse ☐ Child		☐ Medical ☐ Dental ☐ Vision
			☐ Spouse ☐ Child		☐ Medical ☐ Dental ☐ Vision
			☐ Spouse ☐ Child		☐ Medical ☐ Dental ☐ Vision
			☐ Spouse ☐ Child		☐ Medical ☐ Dental ☐ Vision
			☐ Spouse ☐ Child		☐ Medical ☐ Dental ☐ Vision

If any dependent has a different address please note on the back of the form.

I hereby elect the above items to be reduced from my gross paycheck. I recognize that my contributions through payroll reduction are completely voluntary and in compliance with state law. I understand that I cannot revoke or change this compensation reduction any time during the plan year, except for a life event change. Any amounts not claimed during the plan year will be forfeited. Although it is anticipated that a new enrollment form will be completed each year, I understand that if for any reason I fail to complete a new enrollment form, the elections indicated on this form will be honored and the cost of those elections may change.

Signature: _____ Date: _____