

CYPRESS-FAIRBANKS INDEPENDENT SCHOOL DISTRICT

Group Medical Insurance Enrollment Form

For mid-year qualifying event changes only after July 1, 2006

(All newly hired eligible employees **MUST** enroll on-line through the *benefitsConnect*sm system)

FOR PAYROLL DEPARTMENT USE ONLY		Coverage Effective Date:		Spousal Notice Sent:		ENROLLMENT EVENT <input type="checkbox"/> New Hire <input type="checkbox"/> Job Change <input type="checkbox"/> Divorce <input type="checkbox"/> Death <input type="checkbox"/> Other			INSURANCE/DEDUCTION CODE Processor _____			
Employee Number		Name of Employee (Please Print) Last		First		MI		Occupation		Building Assignment		
Social Security Number			Date Employed		Hours Worked per Day <input type="checkbox"/> 7 or more Hours <input type="checkbox"/> Less than 7 Hours		Date of Birth		Age		<input type="checkbox"/> Male <input type="checkbox"/> Married <input type="checkbox"/> Female <input type="checkbox"/> Single	
Home Address:										Home Phone Number		
City, State Zip Code						Spouse's Name (Last, First MI)				Spouse's Date of Birth		

MEDICAL INSURANCE PLAN COVERAGE SELECTION *(Choose only one)*

Elections may not be altered during the Plan Year (May 1 – April 30) unless you and/or your family member(s) experience a "QUALIFYING EVENT" that results in your eligibility to make a change.

A Change Form AND written documentation evidencing any "qualifying event" MUST be presented to the Payroll Dept. NO LATER than 30 DAYS after the qualifying event date.

- Cy-Fair ISD PPO (Preferred Provider Organization) PLAN; contracted with CIGNA Healthcare "*Preferred Provider*" plan
 - Cy-Fair ISD NETWORK (an HMO type plan) PLAN; contracted with CIGNA Healthcare "*Network*" plan
 - Hospital Indemnity Plan (NO COST TO EMPLOYEE) **Not** major medical coverage. For full-time employees only; no dependent coverage available.
- If Electing: Do you have other major medical insurance coverage at this time? _____ YES _____ NO

Coverage Classification <i>(Choose only one)</i>		<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee and Spouse <input type="checkbox"/> Employee and Child(ren) <input type="checkbox"/> Employee and Family			REQUIRED FOR ALL NETWORK PLAN PARTICIPANTS Primary Care Physician PCP ID#	If Dependent Is Over the Age of 19, Eligibility Status Full-time Student OR IRS Dependent		If Dependent is Over the Age of 19, Physically or Mentally Incapacitated? Yes or No
List Only Eligible Dependents for whom Coverage is Desired	Relationship to Employee	Gender M/F	Social Security Number (Required)	Date of Birth		Full-Time Student? YES or NO	IRS Dependent? YES or NO	XXXXXXXXXX
	Self		XXX-XX-XXXX					XXXXXXXXXX
	Spouse							XXXXXXXXXX

EMPLOYEE AUTHORIZATION

I authorize my employer to deduct from my earnings the applicable premium for the coverage I have selected above.

SIGNATURE	DATE
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