Medical Benefits Enrollment Form

ICSVEBA

NOTE: Please Print except for Signature

Employee Information			SSN Required	
Employee Name (Last	First	Middle Initial)	Social Security Number / /	Gender ☐ M ☐ F	Date of Birth (MM/DD/YY) / /
Street Address			Home Phone Number ( )	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ Widowed
City			Business Phone Number ( )	
State	Zip	Country	Occupation	

Dependent Information (Last name required if different from employee's)			SSN Rquired for all Dependents	
Spouse's Name	Date of Birth (MM/DD/YY) / /	Sex ☐ M ☐ F	Social Security Number / /	
Dependent's Name	Date of Birth (MM/DD/YY) / /	Sex ☐ M ☐ F	Social Security Number / /	Relationship ☐ Son ☐ Daughter Other_____
Dependent's Name	Date of Birth (MM/DD/YY) / /	Sex ☐ M ☐ F	Social Security Number / /	Relationship ☐ Son ☐ Daughter Other_____
Dependent's Name	Date of Birth (MM/DD/YY) / /	Sex ☐ M ☐ F	Social Security Number / /	Relationship ☐ Son ☐ Daughter Other_____

Other Insurance Information	
If you or any of your dependents are covered by other Group Insurance, please complete the following information.	
Name of Person covered by other insurance	Social Security Number / /
Name of Company this person works for	Group Number
Name of Insurance Carrier	

Employee Elections			
Apply For:	**Medical Coverage:**	**Life: $20,000**	**Provider Network:**
☐ Employee Only ☐ Employee + Spouse ☐ Employee +Child(ren) ☐ Employee + Family	☐ Comprehensive ☐ Basic ☐ Bronze Option	Life (ee and dep) AD&D (ee and dep)	Blue Shield

EMPLOYEE MUST SIGN HERE	
Employee Signature	Date
X	
E-mail address:	

HUB Office Use ONLY	
Dated Received: _____/_____/_____ Dated Processed: _____/_____/_____	Initials

Employer Use ONLY		
Name of Employer (District) San Pasqual Valley Unifited School District		**Employment Status** ☐ Full Time ☐ Part Time ☐ COBRA
Employment Date	Initials	
Benefits Effective Date		Classification _____ ICSIS # _____

Group Term Life Insurance Beneficiary Designation Form:

ICSVEBA

Group No._____

Employer _____

Member Information:				
Last Name	First Name	MI	SSN	DOB

Primary Beneficiary Designation:						
Last Name	First Name	MI	SSN	DOB	Relationship	% Payable to Each
Address			City		State	ZIP Code
Last Name	First Name	MI	SSN	DOB	Relationship	% Payable to Each
Address			City		State	ZIP Code
Last Name	First Name	MI	SSN	DOB	Relationship	% Payable to Each
Address			City		State	ZIP Code
Last Name	First Name	MI	SSN	DOB	Relationship	% Payable to Each
Address			City		State	ZIP Code

Contingent Beneficiary Designation: *If above beneficiary(ies) predeceases me, I designate the following my contingent beneficiary(ies)*						
Last Name	Fi	MI	SSN	DOB	Relationship	% Payable to Each
Address			City		State	ZIP Code
Last Name	Fi	MI	SSN	DOB	Relationship	% Payable to Each
Address			City		State	ZIP Code

I reserve the right to change this designation at any time. If more than one beneficiary is designated, payment will be made in equal shares, or in proportionate shares based on the percentages designated above, to each surviving beneficiary. If no beneficiary survives the insured,payment shall be made in accordance with the terms of the policy.

Insured's Signature	Date

Witness Signature (someone other than beneficiary)	Date