ADAMS 14
Inspire. Educate. Empower. Inspira. Educa. Fortalece.

Open Enrollment/Change Form

If requesting new enrollment or changes, this form must be completed and returned to HR on or before May 31, 2017

PLEASE PRINT EMPLOYEE INFORMATION					
LAST (Legal) NAME	FIRST (Legal) NAME (i.e. Abigail vs. Abby)		MI	EFFECTIVE DATE **August 1, 2017**	
SOCIAL SECURITY NUMBER	DATE OF BIRTH	GENDER M / F			
HOME ADDRESS	CITY	STATE	ZIP CODE	STATUS: FT or PT	
HOME PHONE		WORK LOCATION	{ } CLASSIFIED { } CERTIFIED { } SUPPORT/TECH { } ADMIN		

SELECT MEDICAL PLAN OR WAIVE COVERAGE:	SELECT DENTAL PLAN OR WAIVE COVERAGE:	SELECT VISION PLAN OR WAIVE COVERAGE
☐ **Kaiser Permanente /** DHMO	☐ **Delta Dental** / PPO Plan	☐ **VSP** / Vision Service Plan
☐ **Kaiser Permanente /** HMO Plan # 230	☐ I ELECT TO WAIVE THIS COVERAGE	☐ I ELECT TO WAIVE THIS COVERAGE
☐ I ELECT TO WAIVE THIS COVERAGE		
SELECT MEDICAL COVERAGE FOR:	**SELECT DENTAL COVERAGE FOR:**	**SELECT VISION COVERAGE FOR:**
☐ Employee Only	☐ Employee Only	☐ Employee Only
☐ Employee + One Dependent	☐ Employee + One Dependent	☐ Employee + One Dependent
☐ Employee + Family	☐ Employee + Family	☐ Employee + Family

PLEASE PRINT ALL TO BE COVERED OR CHANGED

Last (Legal) Name	First (Legal)	MI	SSN Required	Relationship Code **	Birth Date (Required)	Gender M/F	MEDICAL	DENTAL	VISION
				SELF			☐ Add ☐ Drop	☐ Add ☐ Drop	☐ Add ☐ Drop
							☐ Add ☐ Drop	☐ Add ☐ Drop	☐ Add ☐ Drop
							☐ Add ☐ Drop	☐ Add ☐ Drop	☐ Add ☐ Drop
							☐ Add ☐ Drop	☐ Add ☐ Drop	☐ Add ☐ Drop
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**** Relationship Codes: SP = Spouse; DE = Dependent; DD = Disabled Dependent**

If you are electing to waive your Medical insurance through ADAMS 14, you must provide proof of other coverage.

Changes will be reflected on the July 31, 2017 paycheck.

By signing below I am stating that the information provided above is true and correct. I authorize the appropriate payroll deduction, if applicable.

_____

Employee Signature Date