Hire Date: _____

Effective Date: _____

Webb City R-VII School District

☐ **New Enrollment**
☐ **Late Enrollment**
☐ **Change**

EMPLOYEE INFORMATION (To be completed by Employee)					
Last Name	First Name	M.I.	Social Security Number		
Street Address or PO Box mail is to go to		City	State	Zip Code	
Gender	Date of Birth	Email Address	Best Telephone Number		

MEDICAL CARE COVERAGE: (Must be completed)

☐ **Employee Only** ☐ **Emp + 1 Dependent** ☐ **Family** ☐ **I Decline Coverage**

DEPENDENT INFORMATION: .

If you elected dependent coverage, please list each dependent below to be covered by the plan

Name: Last	First	MI..	Gender	Date of Birth	Social Security No.	Relationship

PRIMARY BENEFICIARIES			
1	% 2	% 3	%
LIST THE FULL NAME & PERCENT ALLOCATED TO EACH PERSON ABOVE			

CONTINGENT BENEFICIARIES			
1	% 2	% 3	%
LIST THE FULL NAME & PERCENT ALLOCATED TO EACH PERSON ABOVE			

Name of Spouse's Employer:_____

Are any of the dependents listed above currently covered by any other health insurance program, to include your spouse's employer?

☐ YES ☐ NO If yes, please list the name of the insurance, policy number, and the dependents who are covered by the policy.

I certify the statements above are true and correct to the best of my belief. I hereby authorize any insurance company, prepayment organization, employer, hospital or other health care provider to furnish any information with respect to myself or any of my dependents which may have a bearing on the benefits payable by this or any other Plan providing benefits or services. A photostatic copy of this authorization will be considered as effective and as valid as the original. This authorization will remain in effect until such time that I revoke it in writing.

Signature of Employee Date Signed