GARRETT COUNTY BOARD OF EDUCATION

40 S. Second Street, Oakland, MD 21550

Medical/Dental/Vision Insurance Change Form

□ **POS UMR** □ **PPO UMR** ****Please check the applicable boxes****	□ **Delta Dental** □ **National Vision Administrators**	□ **New Enrollment** □ **COBRA** □ **Decline Coverage**	□ **Add dependents** (Please provide documentation requested when adding new dependents – see attached *Documentation Requirement List*) □ **Drop dependents*** □ **Terminate Coverage*** *See Back of Page	**Status** □ **Active** □ **Retired**

EFFECTIVE DATE :	**DATE OF HIRE:**	**POSITION:**

Plan Choice - Please Check One:	*Individual*	*Employee/Child*	*Employee/Children*	*Husband/Wife*	*Family*	*Two Married Covered Employees WITHOUT Dependents*	*Two Married Covered Employees WITH Dependents*

Primary Enrollee Social Security Number	*Last Name*	*First Name*	*MI*	*Date of Birth*	*Gender* □ **Male** □ **Female**

Employee Number	*Street*	*City*	*State*	*Zip Code*

	Yes	No	Name of Person, Policy Holder, and Policy Number,
Do you or any of your dependents have any other medical coverage?			
Do you or any of your dependents have any other dental coverage?			
Do you or any of your dependents have any other vision coverage?			

Last Name	First Name	MI	M/F	Date of Birth	Date of Marriage	Social Security Number
Subscriber:						
Spouse:						
Dependent:						
Dependent:						

ANY PERSON, WHO WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST ANY INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

Primary Enrollee Signature **Phone Number** **Date**

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*FOR DEPENDENTS BEING DELETED OR FOR TERMINATION OF COVERAGE –

PLEASE COMPLETE THIS PAGE

Last Name	First Name	MI	Medical	Dental	Vision	Reason Code	Termination Date

Reason Codes:

1. **End of Employment**
2. **Divorce**
3. **Death**
4. **Child reached age limit**
5. **Entered military**
6. **Other**