

# CENTRAL INDIANA SCHOOL EMPLOYEES' INSURANCE TRUST

## EMPLOYEE CHANGE/TERMINATION FORM - DENTAL

The Central Indiana School Employees' Insurance Trust is a multiple employer welfare arrangement. The multiple employer welfare arrangement may not be subject to all of the insurance laws and regulations of Indiana. State insurance guaranty funds are not available for this multiple employer welfare arrangement.

Summary Of Changes	<input type="checkbox"/> Emp Name	<input type="checkbox"/> Add Coverage Med / Dent <small>(circle one or both)</small>	<input type="checkbox"/> Drop Employee	<input type="checkbox"/> Coverage Dropped Dental	Change Eff Date: -----
	<input type="checkbox"/> Emp Address	<input type="checkbox"/> Add Spouse	<input type="checkbox"/> Drop Spouse		
	<input type="checkbox"/> Marital Status	<input type="checkbox"/> Add Children	<input type="checkbox"/> Drop Children	<input type="checkbox"/> Early Retiree	

### EMPLOYEE INFORMATION

Last Name	First	Birth Date	Social Security #	Telephone #	
	Middle			( )	
Home Address		City	State	ZIP	

### COMPLETE IF ADDING/CHANGING COVERAGE

DENTAL	Low Dental/Vision			High Dental/Vision			
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Employee	<input type="checkbox"/>			Emp.	<input type="checkbox"/>		
Family	<input type="checkbox"/>			Family	<input type="checkbox"/>		

### COMPLETE IF ADDING/DROPPING SPOUSE

**Eligibility Concerning Your Spouse:**

Last Name	First	Birth Date	Social Security #	Telephone #	
	Middle			( )	

If your spouse is employed, please provide the name of the employer.

Does your spouse have other coverage through their employer?  Yes  No

Please indicate coverage:  Medical  Dental  Vision

### COMPLETE IF ADDING/DROPPING CHILD(REN)

My dependent children, named below meet the following definition:

Yes  No  They are natural children, legally adopted (including a child for whom legal adoption proceedings have been started) and step-children.

Last	Child's Name			DOB	Sex	Relationship			Tax Dependent Yes/No	Full Time Student Yes/No	Provide School Name & Graduation Date for Full Time Student Dependents over Age 18	Court Order Requires That I Provide Health Coverage Yes/No
	First	MI				Natural Child	Step Child	Other				
1						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
2						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
3						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

I declare that the information I have furnished above is true, complete and correct.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

### OFFICE USE ONLY

Hire/Rehire Date	Change Effective Date	Termination Date	Reason
School District/Location <b>Mooreville Shelbyville, BRSE BRC</b>		Plan Administrator Signature	Date