SAN BERNARDINO CITY UNIFIED SCHOOL DISTRICT
EMPLOYEE AND DEPENDENT DATA FORM

☐ ENROLLMENT
☐ DELETE DEPENDENT
☐ ADD DEPENDENT

EFFECTIVE DATE ___________________

____
Qualifying Event Reason

EMPLOYEE INFORMATION:

FIRST NAME | M.I. | LAST NAME AND TITLE (SR, JR, ETC.) | SOCIAL SECURITY NUMBER ___ - __ - ____ | SEX

Dr. or PCP No. & GRP or PPG No. ______ Existing Patient Yes ☐ No ☐ ______ Dentist Name & Provider #

Please provide the requested information for your dependents that you are adding or deleting. Eligible dependents include: spouse (unless divorced or legally separated), dependent children, including stepchildren, legally adopted children, children for whom you have legal custody and children of a domestic partner. (Dependents in the military are not eligible for coverage). Domestic Partner as defined under California's Family Code Section 297.

***RELATIONSHIP CODES: H=Husband W=Wife P=Domestic Partner S=Son D=Daughter E=Child of Domestic Partner or Stepchildren**

FIRST NAME | M.I. | DATE OF BIRTH (M M D D Y Y Y Y) | SEX | SOCIAL SECURITY NUMBER ___ - __ - ____

LAST NAME AND TITLE (SR, JR, ETC.) | *RELATION-SHIP | DISABLED Y/N | Dr. or PCP No. & GRP or PPG No. Existing Patient ☐ Yes ☐ No | Dentist Name & Provider #

FIRST NAME | M.I. | DATE OF BIRTH (M M D D Y Y Y Y) | SEX | SOCIAL SECURITY NUMBER ___ - __ - ____

LAST NAME AND TITLE (SR, JR, ETC.) | *RELATION-SHIP | DISABLED Y/N | Dr. or PCP No. & GRP or PPG No. Existing Patient ☐ Yes ☐ No | Dentist Name & Provider #

FIRST NAME | M.I. | DATE OF BIRTH (M M D D Y Y Y Y) | SEX | SOCIAL SECURITY NUMBER ___ - __ - ____

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OTHER INSURANCE

Does any member of your family — including you — have other group insurance, including Medicare? ☐ Yes ☐ No

If yes, please indicate: Employer ___________________________

Insurance Company ___________________________

Policy No. or ID No. ___________________________

*I declare under penalty of perjury that the person(s) listed as my dependents are eligible dependents as described in the District's Employee Benefits Handbook. I understand that I may be held responsible for ALL COSTS if the District determines my dependent(s) are not eligible for benefits coverage.

SIGNATURE ___________________________ DATE ______________

BU-99a (Rev. 4/15) White - Employer Yellow - Employee