ST. CLAIRSVILLE SCHOOLS
RECORD CHANGE FORM
506-448

PLEASE PRINT OR TYPE

NAME OF EMPLOYEE____ SOC. SEC. NO.__________________

_________CHANGE OF NAME

Change name from______________________________to______________________________

Date of change__________________

__________ADDITION OF DEPENDENTS **(If coverage includes dependents, you *must* attach proof of marriage, birth, etc. Give last name of dependent if other than yours.)**

Name of Spouse____________________Date of Marriage ____________ SS#________________DOB__________

Name of Dep______________________Sex______ Rel__________ SS#________________DOB__________

Name of Dep______________________Sex______ Rel__________ SS#________________DOB__________

Name of Dep______________________Sex______ Rel__________ SS#________________DOB__________

Is your spouse employed? (YES)______(NO)______**If YES, where?**______________________________

Do ALL covered dependents live at the same address as above? (YES) _____ (NO)_____

If NO, please provide dependent name and address: ______________________________

If child(ren) is over age 23 - 25 and a full-time student, list child's name and name of school __________________

Do you, your spouse or any of your dependents have other dental coverage (through Medicare or another plan?) (YES)____(NO)____

If YES, list name of insurance company, type of coverage and individuals covered______________________

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___________ADDITION OF COVERAGE

Type of coverage (medical, dental, etc.)____________________

Effective date of coverage__________________

Will coverage include dependents? (YES)_____ (NO)_____

If YES, complete dependent section above.

___________DELETION OF DEPENDENTS

Name of dependent____

Reason for deletion____

Date of deletion____________________

___________OTHER CHANGE (i.e. address change, salary, etc.)

Describe change and effective date____

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I HEREBY CERTIFY THAT THE ABOVE STATEMENTS ARE ACCURATE. I AUTHORIZE ANY PERSON OR INSTITUTION RENDERING CARE, OR ANY PERSON OR ORGANIZATION (INCLUDING MY EMPLOYER) IN POSSESSION OF INFORMATION CONCERNING INSURANCE OR OTHER BENEFITS COVERING ME OR MY DEPENDENTS, TO FURNISH TO, OR RECEIVE FROM SELF-FUNDED PLANS, INC. OR ITS AUTHORIZED REPRESENTATIVE, FULL INFORMATION REGARDING SUCH CARE OR OTHER BENEFIT INFORMATION. THIS AUTHORIZATION SHALL REMAIN IN EFFECT FOR AS LONG AS MY DEPENDENTS AND I ARE ELIGIBLE TO RECEIVE BENEFITS UNDER THE PLAN. A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.

PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY MISREPRESENTATION OR ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW AND MAY BE SUBJECT TO CIVIL PENALTIES.

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SIGNATURE OF EMPLOYEE____DATE________________

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01/18.11