School Claims Service
SCS

FRINGE BENEFITS ENROLLMENT/CHANGE FORM

SCHOOL DISTRICT _____ GROUP NUMBER _____ DIVISION NUMBER _____

☐ NEW EMPLOYEE ☐ REHIRE ☐ REINSTATE
☐ TERMINATED ☐ RETIRED ☐ COBRA
☐ Change of Name ☐ Change of Address ☐ Change of Phone
☐ Change Birthdate ☐ Change Hire Date ☐ Change Identification Number
☐ Change Effective Date ☐ Add Spouse/Dependent(s) ☐ Change Spouse/Dependent Status
☐ Delete Spouse/ Dependent(s)

NOTES:

PRINT NAME OF EMPLOYEE _____ (FIRST) _____ (MIDDLE) _____ (LAST)

_____ SOCIAL SECURITY #

☐ **MALE** ☐ **WIDOWED**
☐ **FEMALE** ☐ **SINGLE**
☐ **MARRIED** ☐ **DIVORCED**

_____ ADDRESS

_____ TELEPHONE #

_____ ADDRESS

OCCUPATION _____

☐ I elect to be covered under the Fringe Benefits Plan for which I am, or may be, eligible as indicated: (check appropriate boxes) ☐ **DENTAL BENEFITS**
- ☐ Employee
- ☐ Spouse
- ☐ Dependent Children

	MONTH	DAY	YEAR
BIRTH DATE			
EMPLOYMENT DATE			
EFFECTIVE DATE			

☐ I do not want to be covered under the Fringe Benefits Plan for which I am eligible. I understand that I will have to submit satisfactory medical evidence of good health if I want this coverage after my initial period of enrollment has expired.

_____ EMPLOYEE SIGNATURE REQUIRED

_____ DATE

Please list spouse/dependents you wish to have covered under this plan.

NAME: FIRST MIDDLE LAST	**Relationship** (spouse – son – daughter)	**Social Security Number (If F/T student, also provide name of institution and graduation date)**	**F/T Student** Yes No	**Birth Date** Month	Day	Year

Is spouse employed? ☐ **Yes** ☐ **No** **If yes, please provide name of spouse's employer for coordination of benefits:** _____

Spouse's Social Security # _____ **Spouse Dental/Vision Insurance Carrier** _____

Fax to School Claims Service, LLC at (866) 403-7701 or email to DVEnrollment@psba.org.

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