Effective Date: _____

Bronxville Public School Employee Benefit Trust Fund
CHANGE FORM

☐ Change of Life Status (marriage, divorce, death, birth, retirement)
☐ ADD / DROP Benefit(s) ☐ ADD / DROP Dependent(s) ☐ Change of Address ☐ Correction

Employee Information – Please fill out this ENTIRE section.

1. Employee Name (Last, First, MI): _____ 2. Employee SS#: _____

3. Employee Address: _____

_____

_____

4. Employee Home Phone: _____ 5. SEX: ☐ Male ☐ Female

6 Date of Birth (Mo, Day, Year): _____ / _____ / _____

7. Marital Status: ☐ Single ☐ Married ☐ Domestic Partner

8. Date Employed (Mo, Day, Year): _____ / _____ / _____ ☐ Full-time ☐ Part-time

9. Hours worked weekly for this employer (Excluding Overtime) _____ ☐ Active ☐ Retired

10. Employee Salary $_____ ☐ Hourly _____Hrs/Wk ☐ Weekly ☐ Monthly ☐ Annually

11. Employee's Title: _____

Changes to Group Benefits

Life/AD&D ☐ ADD ☐ DROP
Dental ☐ ADD Family Coverage ($25.20 per month) ☐ DROP Family Coverage
Vision ☐ ADD Dependent(s) ($50 per year per dependent) ☐ DROP Dependent(s)
Names of ☐ added / ☐ dropped dependent(s) for Vision Coverage:

_____

**$50K EMPLOYEE Supplemental Life/AD&D @ $16.50 per month ☐ ADD ☐ DROP
**Dependent Life/AD&D ($5,000 for Spouse; $1,000 for Dependent) @ $1.61 per month per person ☐ ADD ☐ DROP
Names of ☐ added / ☐ dropped dependent(s) for Dependent Life/AD&D:

_____

__Please note:__ If you add supplemental OR dependent life insurance after the initial enrollment period, you **must complete an **EVIDENCE OF INSURABILITY** form in order to determine eligibility of coverage.

Dependent Information

Relationship	Add/Drop	Last Name	First Name	MI	Date of Birth	Sex	Social Security #
					/ /		
					/ /		
					/ /		
					/ /		
					/ /		

Student Verification – Please attach a student verification form from the student's registrar if any child listed is a full-time college student.

Beneficiary Designation for Life Insurance

__Primary:__

Last Name: _____ First Name & Middle Initial: _____

Relationship: _____ Address: _____

__Contingent:__

Last Name: _____ First Name & Middle Initial: _____

Relationship: _____ Address: _____

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent act, which is a crime, and shall be subjected to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

The information provided above is true and correct to the best of my knowledge.

Employee Signature: _____ Date: _____

updated 11/2007