ENROLLMENT AND CHANGE

Complete the following after reading the Trust's enrollment materials, and submit the signed, dated form to your Payroll/Personnel officer within 31 days of your one-year anniversary date of continuous State service or 31 days of your family/work status change.

☐ NEW ENROLLMENT ☐ FAMILY/ WORK STATUS CHANGE Date of change_____/_____/_____

☐ Marriage ☐ Divorce
☐ Birth, adoption, guardianship ☐ Agency transfer
☐ Switch from exempt to Union-represented

MEMBER

Last Name First Name MI SSN County

Street Address City State ZIP Code

Worksite Office Telephone Number Date of Birth

DENTAL

	Single	Family
☐ Preferred Choice	☐	☐
☐ Quality Dental	☐	☐
☐ Waive Dental coverage		

VISION

	Single	Family
☐ EyeMed	☐	☐
☐ VSP	☐	☐
☐ Waive Vision coverage		

DEPENDENTS

Updating dependent information? Make sure you mark the appropriate family status change box(es) above before completing the section below. Attach a separate sheet if necessary. List your spouse first, then your eligible dependent children.

First Name	Last Name *(if different from yours)*	SSN	Birthdate	Sex	Relation	Add to		Drop from	
					Spouse	D	V	D	V
					Child	D	V	D	V
					Child	D	V	D	V
					Child	D	V	D	V

You may be required to file an affidavit for your dependents; talk with your Payroll/Personnel officer about this.

I certify the above information to be accurate. I understand I must submit this form within the enrollment/change period as described in Trust enrollment materials, and that submitting the form prior to my anniversary/change date helps to ensure that coverage will begin the effective date as described in the plan booklets.

Member Signature Date

THIS SECTION TO BE COMPLETED BY AGENCY DESIGNEE:

Employee Appointment Date CBU Agency Effective Date

Signature of Agency Designee Date Designee Phone Number

You are responsible for verifying eligible dependents and providing the effective date.