SOUTH CENTRAL INDIANA SCHOOL TRUST
Employee Change/Termination Form Group # SCIST

The South Central Indiana School Trust is a multiple employer welfare arrangement. The multiple employer welfare arrangement may not be subject to all of the insurance laws and regulations of Indiana. State insurance guaranty funds are not available for this multiple employer welfare arrangement.

Summary Of Changes	☐ Employee Name	☐ Add Medical/Dental	☐ Drop Employee	☐ Medical Dropped	**Effective Date of Change:**
	☐ Employee Address	☐ Add Spouse	☐ Drop Spouse	☐ Dental Dropped	
	☐ Marital Status	☐ Add Children	☐ Drop Children	☐ Early Retiree	

EMPLOYEE INFORMATION

Employee Last Name	First	Initial	Social Security Number or Anthem ID Number
Street Address			Phone ( )
City, State, Zip			Sex (M/F) / Date of Birth

Marital Status: ☐ Single ☐ Married (Date) _____ ☐ Divorced (Date) _____ ☐ Widowed (Date)

Add or Dropping	☐ PPO $1,500 Single $3,000 Family	☐ PPO $5,000 Single $10,000 Family	☐ HDHP/HSA $2,000 Single $4,000 Family	☐ HDHP/HSA $3,000 Single $6,000 Family	☐ Dental	
Employee						
EE+Spouse						
EE+Child(ren)						
Family						

COMPLETE IF ADDING/DROPPING SPOUSE

Spouse's Last Name	First	Initial	Date of Birth
Name of Spouse's Employer			Spouse's Social Security #
Employer Street Address: City, State, Zip, Phone Number with Area Code			
Does your spouse have other insurance coverage through their employer? ☐ Yes ☐ No			
If "yes, please indicate which coverage: ☐ Medical ☐ Dental			

COMPLETE IF ADDING/DROPPING CHILD(REN)

Full Name of Dependent	**Social Security # MUST HAVE**	Sex (M/F)	Date of Birth	Under Age 26 Yes/No		

Other Group Insurance Coverage including Medicare

Is other coverage provided for any other family member for Medical or Dental ☐ Yes ☐ No (If "Yes" then please list the family member and type of coverage.)

Name of Family Member	Type of Coverage (Medical, Dental)

I declare that the information I have furnished above is true, complete and correct.

_____
Employee Signature Date

Revised 08 -2016 OFFICE USE ONLY

Hire/Rehire Date	Coverage Effective Date	Termination Date	List Reason **Death of Active EE** ☐	
Plan Administrator Signature	Date	School Corporation Name		Location #

Updated 08-09-2016