To be filled out by employees with health insurance through the District

Medical Benefits - CHANGE / TERMINATION FORM

ICSVEBA

EMPLOYEE INFORMATION

Last Name	First Name	Initial	Social Security Number (required)

REASON FOR REQUESTED CHANGE

Benefits Change Effective Date: / /

1. Addition of Dependent Coverage — Date of Marriage, Birth, Adoption / /
   - ☐ Spouse ☐ Natural Child
   - ☐ Adopted Child ☐ Stepchild
2. Termination of ALL Dependent Coverage - Reason — Effective Date / /
3. Termination of Named Dependent(s) — Effective Date / /
   - ☐ Spouse ☐ Child(ren)
   - Name(s)
   - Reason(s)
4. Change Plan Option (Open Enrollment Only) — Effective Date / /
   - From: _____ To: _____
5. Change Status — Effective Date / /
   - ☐ Retiree Retiree Age _____
   - ☐ COBRA ☐ Retiree Plan
6. Termination of Life Insurance — Effective Date / /
   - ☐ Basic Life ☐ AD&D ☐ Dependent Life
7. Reinstate Coverage — Effective Date / /
   - ☐ ALL ☐ Employee ☐ Dependent
8. Cancel ALL Coverage — Effective Date / /
   - ☐ Termination of Employment ☐ Leave/Lay Off
9. Other Changes
   - ☐ Name ☐ Address

Name

Address

City Zip Country

EMPLOYEE ELECTION

- ☐ Employee Only
- ☐ Employee + Spouse
- ☐ Employee + Child(ren)
- ☐ Employee + Family

NETWORK SELECTED

Blue Cross - CA

COVERAGE SELECTED

- ☐ Comprehensive Option
- ☐ Basic
- ☐ SIMNSA (Mexico ONLY)

DEDUCTION (Board Members & Retirees ONLY)

- ☐ One lump sum (due by Aug 30)
- ☐ 2 equal payments (due Aug 31 & Jan 31)
- ☐ 10 Equal payments (due last day of each month Aug - May)

EMPLOYER USE ONLY

Name of EMPLOYER (District): IMPERIAL COMMUNITY COLLEGE DISTRICT / IMPERIAL VALLEY COLLEGE

Employment Date

Employment Status

- ☐ Faculty
- ☐ Classified
- ☐ Confidential
- ☐ Administrator
- ☐ Manager
- ☐ Board Member
- ☐ Retiree

HUB OFFICE USE ONLY

Initials

Date Received: _____

Date Processed: _____

Initials

EMPLOYEE MUST SIGN HERE

Employee Signature Date

X

E-mail Address:

Use this space to list eligible dependent changes. Last name required if different from employee's

SSN Required for all dependents

Spouse's Name	Date of Birth / /	Sex ☐ M ☐ F	SSN	
Dependent's Name	Date of Birth / /	Sex ☐ M ☐ F	SSN	Relationship ☐ Son ☐ Daughter Other
Dependent's Name	Date of Birth / /	Sex ☐ M ☐ F	SSN	Relationship ☐ Son ☐ Daughter Other