Fresno Unified School District
2309 Tulare Street Fresno, CA 93721
(559) 457-3520 Fax No. (559) 457-3760

SPECIAL ENROLLMENT FORM
BENEFITS ELIGIBLE EMPLOYEES

1. EMPLOYEE INFORMATION

LAST NAME	FIRST NAME	FUSD EMPLOYEE I.D. / SSN	☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DOMESTIC PARTNERSHIP ☐ ACTIVE ☐ RETIREE ☐ LEAVE

MAILING ADDRESS	BIRTHDATE	TELEPHONE NO.	☐ MALE ☐ FEMALE

CITY	STATE	ZIP CODE	DEPARTMENT / SCHOOL

2. OTHER HEALTH INSURANCE INFORMATION

Is your spouse employed? ☐ YES ☐ NO IF YES, WHERE? ☐ FUSD ☐ OTHER: _____

Are you or any family members covered by another group plan? ☐ NO ☐ YES _____
GROUP NAME

****PLEASE NOTIFY THE BENEFITS OFFICE OF ANY CHANGES IN HEALTH COVERAGE WITHIN 31 DAYS OF EVENT****

ENROLLED IN MEDICARE? ☐ NO ☐ YES **PART A** EFFECTIVE DATE _____ **PART B** EFFECTIVE DATE _____

3. LIFE EVENTS

LIFE EVENT: Select one and provide the indicated documents

☐ Newborn (copy of Birth Certificate)
☐ Marriage (copy of Marriage Certificate)
☐ Death (copy of Death Certificate)
☐ Other Coverage or Loss of Coverage (Verification of new/loss of coverage is required) If new coverage, who is it through: _____
☐ Domestic Partnership (copy of Domestic Partner Certificate)
☐ Divorce (copy of Decree)
☐ Termination of Domestic Partnership (copy of Decree)

4. FAMILY INFORMATION – LIST DEPENDENTS AND PROVIDE COPIES OF:
BIRTH CERTIFICATES / MARRIAGE OR DOMESTIC PARTNER CERTIFICATES / SS# COPY

FIRST NAME	LAST NAME	GENDER	AGE	BIRTHDATE	SOCIAL SECURITY #
☐ DOMESTIC PARTNER ☐ SPOUSE		☐ F ☐ M			
☐ SON ☐ DAUGHTER		☐ F ☐ M			
☐ SON ☐ DAUGHTER		☐ F ☐ M			
☐ SON ☐ DAUGHTER		☐ F ☐ M			
☐ SON ☐ DAUGHTER		☐ F ☐ M			
☐ SON ☐ DAUGHTER		☐ F ☐ M			

5. CHANGES TO EXISTING BENEFITS

	ADD	DELETE	ADD/ DELETE WHOM	PLAN CHANGES
HEALTH	☐	☐	☐ Spouse ONLY ☐ Dependent(s) ONLY ☐ Family	☐ No Change to Medical Plan ☐ Change to Medical Option A ☐ Change to Medical Option B ☐ Change to Medical Option C
DENTAL	☐	☐	☐ Spouse ONLY ☐ Dependent(s) ONLY ☐ Family	☐ No Change to Dental Plan ☐ Change to Delta Dental ☐ Change to PUD
VISION	☐	☐	☐ Spouse ONLY ☐ Dependent(s) ONLY ☐ Family	☐ No Change to Vision Plan ☐ Change to MES (Plan A & B ONLY) ☐ Change to Kaiser Vision (Kaiser Members ONLY)
DEPENDENT LIFE	☐	☐	☐ Spouse ONLY ☐ Dependent(s) ONLY ☐ Family	

*The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) provides for continued group health care coverage for employees and family members at their own expense. Contact the Benefits Office for continuation of coverage due to a qualifying event.

EMPLOYEE SIGNATURE_____ **DATE** _____

Verified by:	Effective Date: