Medical Benefits - CHANGE / TERMINATION FORM

ICSVEBA

EMPLOYEE INFORMATION

Last Name	First Name	Initial	Social Security Number

REASON FOR REQUESTED CHANGE

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

EMPLOYEE ELECTION

- ☐ Employee Only
- ☐ Employee + One
- ☐ Employee + Family

NETWORK SELECTED

COVERAGE SELECTED

- ☐ Comprehensive Option
- ☐ Comprehensive + Frontera Option

EMPLOYER USE ONLY

Name of EMPLOYER (District): Imperial Community College District / Imperial Valley College

Employment Date

Employment Status

- ☐ Full Time ☐ Retiree ☐ COBRA (attach form)
- ☐ Part Time ☐ Disabled

EJP OFFICE USE ONLY

Date Received: _____

Date Processed: _____

Processor: _____

EMPLOYEE MUST SIGN HERE

Employee Signature Date

X

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

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