Reading School District

Enrollment and Change Form

Employee Name (Last / First / Middle Initial)	Social Security Number	Sex	Date of Birth (MM/DD/YY)
		M ☐ F ☐	/ /

Home Address	Home Phone Number
	( )
City	
State / ZIP	
*Primary Care Physician (Required only if selecting Managed Care Plan)	

Marital Status	Apply For	Apply For Health Coverage
☐ Single	☐ Self	☐ Managed Care Plan *A Primary Physician must be chosen for each enrollee.
☐ Married	☐ Self & Spouse	☐ PPO Plan
☐ Divorced	☐ Self & Children	☐ PPO 2
☐ Widowed	☐ Self & Family	
	☐ Decline Coverage	

The Loomis Company Use Only

Remarks

Effective Date Employee

Effective Date Dependent

Processed Date	User I.D.

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

Spouse's Name	*Primary Care Physician	Date of Birth (MM/DD/YY) / /	Sex ☐M ☐F	Social Security Number		
Dependent's Name	*Primary Care Physician	Date of Birth (MM/DD/YY) / /	Sex ☐M ☐F	Social Security Number	Relationship ☐ Son ☐ Daughter Other _____	Full Time Student ☐Yes ☐ No
Dependent's Name	*Primary Care Physician	Date of Birth (MM/DD/YY) / /	Sex ☐M ☐F	Social Security Number	Relationship ☐ Son ☐ Daughter Other _____	Full Time Student ☐Yes ☐ No
Dependent's Name	*Primary Care Physician	Date of Birth (MM/DD/YY) / /	Sex ☐M ☐F	Social Security Number	Relationship ☐ Son ☐ Daughter Other _____	Full Time Student ☐Yes ☐ No
Dependent's Name	*Primary Care Physician	Date of Birth (MM/DD/YY) / /	Sex ☐M ☐F	Social Security Number	Relationship ☐ Son ☐ Daughter Other _____	Full Time Student ☐Yes ☐ No

If you or any of your covered dependents are covered by other insurance, please fill out the following information:

Other Insurance Information

Name of Person covered by other insurance	
Name of Company providing other insurance	Group No.
Name of other Insurance Company	
Address of other Insurance Company	

Group #	Name of Employer	
305	**Reading School District**	
	Date Hired	**Employment Status** ☐ Full Time ☐ Part Time ☐ COBRA ☐ Retiree
Retirement Date	Effective Date	
Location	☐ Hourly ☐ Salaried	Initials
Comments		

Check All That Apply

- ___ Open Enrollment
- ___ New Enrollment
- ___ Termination of Coverage
- ___ Change (specify)
  - ___ Add Dependent/Spouse
  - ___ Change Physician
  - ___ New Address
  - ___ Change of Employee Status
  - ___ Delete Dependent/Spouse
  - ___ Reinstate
  - ___ COBRA
  - ___ Other (specify): _____

Employee Signature **Date**