Cedarburg School District

Challenging Students to Achieve Their Goals and Dreams

Insurance Application Information

Full-time employees (those who are scheduled to work at least 30 hours per week for the entire school year) are eligible for health, dental and/or vision insurance. Applications for insurance benefits may be submitted by eligible employees:

1. upon being hired by the District;
2. during the annual open enrollment window (mid-November through early December);
3. within 30 days of a qualifying event (i.e., birth of a child, marriage, divorce, etc.).

Original completed application must be received by the payroll department in a timely manner.

Please direct questions to the Payroll/Benefits Office at extension 6113.

Enrollment/Change Form

Please print in all capital letters using blue or black ink. Please complete all sections. Required sections are marked with an *.

Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri

Employer Information: to be completed by Employer

Employer Name*: CEDARBURG SCHOOL DISTRICT

Effective Date*^: ___ / ___ / ____

^Date set by employer in accordance with EyeMed proposal. Employer also sets effective date for new adds during contract period.

Group Number*: 1025716

Subgroup*: 1001

Location Code:

Employee Information: to be completed by Employee

Change Type*: ☐ Add ☐ Term ☐ Update

Member ID:

Last Name*:

Date of Birth*: ___ / ___ / ____

First Name*:

MI:

Gender*: ☐ Male ☐ Female

Phone Number: ( ) -

Street Address*:

City*:

State*:

Zip Code*:

Social Security Number*^: - -

^Last four digits of Employee's Social Security Number are required.

Employee Email Address:

Family Information: to be completed by Employee. Only eligible dependents may be enrolled.

Dependent 1

Change Type*: ☐ Add ☐ Term ☐ Update

Relationship*: ☐ Husband ☐ Wife ☐ Son ☐ Daughter ☐ Domestic Partner

Last Name*:

Gender*: ☐ Male ☐ Female

First Name*:

MI:

Social Security Number: - -

Date of Birth*: ___ / ___ / ____

Dependent 2

Change Type*: ☐ Add ☐ Term ☐ Update

Relationship*: ☐ Husband ☐ Wife ☐ Son ☐ Daughter ☐ Domestic Partner

Last Name*:

Gender*: ☐ Male ☐ Female

First Name*:

MI:

Social Security Number: - -

Date of Birth*: ___ / ___ / ____

Dependent 3

Change Type*: ☐ Add ☐ Term ☐ Update

Relationship*: ☐ Husband ☐ Wife ☐ Son ☐ Daughter ☐ Domestic Partner

Last Name*:

Gender*: ☐ Male ☐ Female

First Name*:

MI:

Social Security Number: - -

Date of Birth*: ___ / ___ / ____

Dependent 4

Change Type*: ☐ Add ☐ Term ☐ Update

Relationship*: ☐ Husband ☐ Wife ☐ Son ☐ Daughter ☐ Domestic Partner

Last Name*:

Gender*: ☐ Male ☐ Female

First Name*:

MI:

Social Security Number: - -

Date of Birth*: ___ / ___ / ____

I hereby represent that I have reviewed the fraud warning notice on the reverse side of this application for the Employee's resident state.

Employee Signature*: _____ Date*: ___ / ___ / ____

For additional dependents, please complete a second form.