CITY OF SPOKANE

Self-Funded Benefits Program

Local 270 CHANGE FORM

☐ Address Change
☐ Name Change From:

☐ Adding Dependents
☐ Removing Dependents

Reason _____

Effective Date / /

☐ Dental
☐ Premera Plan 5
☐ Premera Plan 6
☐ Kaiser Plan 3
☐ Kaiser Plan 4

EMPLOYEE: COMPLETE THE FOLLOWING

SSN

LAST NAME **FIRST NAME** **M.I.**

ADDRESS **APT. NO.**

CITY **STATE** **ZIP CODE**

CHECK ONE Add	Remove	LAST NAME	FIRST NAME	M.I.	Med-ical	Den-tal	Birthdate	Sex M/F	Social Security No.
☐	☐	Spouse							
☐	☐	Child							
☐	☐	Child							
☐	☐	Child							
☐	☐	Child							
☐	☐	Child							
☐	☐	Child							

ARE YOUR DEPENDENTS NAMED ABOVE COVERED BY OTHER GROUP MEDICAL? ☐ NO ☐ YES

COVERED BY: _____
Name of Insurance Company INSURANCE COMPANY ADDRESS

POLICY HOLDER POLICY NUMBER EFFECTIVE DATE

ARE YOUR DEPENDENTS NAMED ABOVE COVERED BY OTHER GROUP DENTAL? ☐ NO ☐ YES

COVERED BY: _____
Name of Insurance Company INSURANCE COMPANY ADDRESS

POLICY HOLDER POLICY NUMBER EFFECTIVE DATE

DECLARATION

In applying for enrollment as indicated on this form, I acknowledge that if I have intentionally submitted inaccurate information for dependent eligibility coverage the City may cancel my insurance benefits and direct me to repay costs for benefits inappropriately received. The City may also take such legal action as it deems necessary. The changes on this form supersede all previous forms submitted. I authorize the City of Spokane to deduct from my earnings the amount, if any, for the coverage selected.

SIGNATURE _____ **DATE** _____