

**CITY OF SPOKANE**  
Self-Funded Benefits Program

**CHANGE FORM**

<input type="checkbox"/> Address Change		
<input type="checkbox"/> Name Change From:		
<input type="checkbox"/> Adding Dependents		<input type="checkbox"/> Dental
<input type="checkbox"/> Removing Dependents		<input type="checkbox"/> Plan III
Reason _____		<input type="checkbox"/> Plan IV
Effective Date    /    /		

**EMPLOYEE: COMPLETE THE FOLLOWING**

SSN		
LAST NAME	FIRST NAME	M.I.
ADDRESS		APT. NO.
CITY	STATE	ZIP CODE

CHECK ONE <small>Add    Remove</small>	LAST NAME	FIRST NAME	M.I.	Med- ical	Den- tal	Birthdate	Sex M/F	Social Security No.
<input type="checkbox"/> <input type="checkbox"/>	Spouse							
<input type="checkbox"/> <input type="checkbox"/>	Child							
<input type="checkbox"/> <input type="checkbox"/>	Child							
<input type="checkbox"/> <input type="checkbox"/>	Child							
<input type="checkbox"/> <input type="checkbox"/>	Child							
<input type="checkbox"/> <input type="checkbox"/>	Child							
<input type="checkbox"/> <input type="checkbox"/>	Child							

ARE YOUR DEPENDENTS NAMED ABOVE COVERED BY OTHER GROUP MEDICAL? <input type="checkbox"/> NO <input type="checkbox"/> YES		
COVERED BY: _____		
<small>Name of Insurance Company</small>		<small>INSURANCE COMPANY ADDRESS</small>
POLICY HOLDER	POLICY NUMBER	EFFECTIVE DATE

ARE YOUR DEPENDENTS NAMED ABOVE COVERED BY OTHER GROUP DENTAL? <input type="checkbox"/> NO <input type="checkbox"/> YES		
COVERED BY: _____		
<small>Name of Insurance Company</small>		<small>INSURANCE COMPANY ADDRESS</small>
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 \_\_\_\_\_