SCHOOL DISTRICT OF PHILADELPHIA

Member Application and Change Form
Phone: (215) 400-4630 Fax: (215) 400-4631

Instructions: This application allows you to enroll in a School District of Philadelphia (SDP) insurance plan(s), or to make certain changes if you are already a member. Carefully fill out the form and print clearly.

❶ Employee Information

First Name	
Last Name	
Social Security Number	_ _ _ - _ _ - _ _ _ _
Daytime Phone Number	

❷ Reason for Application

Application Type: *Select One*

- ☐ New Hire/Rehire
- ☐ Open Enrollment:
  Requests must be received between May 1 and May 31. Changes are effective July 1.
- ☐ Qualifying Life Event:
  Requests must be received within thirty (30) days of the life event date along with appropriate documentation. We reserve the right to adjust bi-weekly premiums due to Life Event change in enrollment status

Request Type: *Select all that apply*

- ☐ Elect Coverage
- ☐ Terminate Coverage
- ☐ Add spouse/dependent(s)
- ☐ Remove spouse/dependent(s)
- ☐ Change Plan Type
- ☐ Other: ______________________

❸ Select a Plan Type

Medical Plans: *Select One*

- ☐ HMO-Keystone Health Plan East
- ☐ PPO-Personal Choice 20/30/70%
- ☐ PPO-Modified Personal Choice 320
- ☐ **Waive** Medical Insurance

Ancillary Plans: *Select all that apply*

Non-Represented, CASA & SPAP only

- ☐ Dental- United Concordia
- ☐ Vision & Prescription- IBC
- ☐ **Waive** Ancillary Insurance

The HMO and PPO Plans may be subject to a biweekly premium. See website for current rates.
Refer to the Eligibility Chart on the back side to select the appropriate medical plan.

❹ Covered Family Member Information

Complete all information for each person to be covered. You must provide documentation for each dependent. See back of application for a description of the required documents.

		First Name	MI	Last Name
SPOUSE* ☐Add ☐Remove	☐Med., Vis. &Rx. ☐Dental			
		Social Security Number	**Gender**	**Date of Birth**
			M F	

* **CASA & Non-Represented** employees must complete the *Letter of Attestation*. See back side of the application for the *Letter of Attestation.*

		First Name	MI	Last Name
CHILD ☐Add ☐Remove	☐Med., Vis. &Rx. ☐Dental			
		Social Security Number	**Gender**	**Date of Birth**
			M F	
CHILD ☐Add ☐Remove	☐Med., Vis. &Rx. ☐Dental	**First Name**	**MI**	**Last Name**
		Social Security Number	**Gender**	**Date of Birth**
			M F	
CHILD ☐Add ☐Remove	☐Med., Vis. &Rx. ☐Dental	**First Name**	**MI**	**Last Name**
		Social Security Number	**Gender**	**Date of Birth**
			M F	

❺ Signature and Verification- Read carefully and sign

Your application CANNOT be processed without your signature. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to employment, criminal and civil penalties.

____________________________________ ____________
Employee Signature **Date**

INTEROFFICE USE ONLY	EFFECTIVE DATE OF COVERAGE	DOCUMENTS/NOTES