CM REGENT SOLUTIONS

FRINGE BENEFITS ENROLLMENT/CHANGE FORM

SCHOOL DISTRICT _____ GROUP NUMBER _____ DIVISION NUMBER _____

☐ NEW EMPLOYEE ☐ TERMINATED ☐ Change of Name ☐ Change Birthdate ☐ Change Effective Date ☐ Delete Spouse/ Dependent(s)
☐ REHIRE ☐ RETIRED ☐ Change of Address ☐ Change Hire Date ☐ Add Spouse/Dependent(s)
☐ REINSTATE ☐ COBRA ☐ Change of Phone ☐ Change Identification Number ☐ Change Spouse/Dependent Status

NOTES:

PRINT NAME OF EMPLOYEE _____ (FIRST) (MIDDLE) (LAST) _____ SOCIAL SECURITY #

☐ **MALE** ☐ **WIDOWED**
☐ **FEMALE** ☐ **SINGLE**
☐ **MARRIED** ☐ **DIVORCED**

_____ ADDRESS _____ TELEPHONE #

_____ ADDRESS OCCUPATION _____

☐ I elect to be covered under the Fringe Benefits Plan for which I am, or may be, eligible as indicated:
(check appropriate boxes)

☐ **DENTAL BENEFITS**	☐ **VISION BENEFITS**	☐ **OPTI-VISION**
☐ Employee	☐ Employee	☐ Employee
☐ Spouse	☐ Spouse	☐ Spouse
☐ Dependent Children	☐ Dependent Children	☐ Dependent Children

	MONTH	DAY	YEAR
BIRTH DATE			
EMPLOYMENT DATE			
EFFECTIVE DATE			

☐ I do not want to be covered under the Fringe Benefits Plan for which I am eligible. I understand that I will have to submit satisfactory medical evidence of good health if I want this coverage after my initial period of enrollment has expired.

_____ EMPLOYEE SIGNATURE REQUIRED _____ DATE

Please list spouse/dependents you wish to have covered under this plan.

NAME: FIRST MIDDLE LAST	**Relationship** (spouse – son – daughter)	**Social Security Number (If F/T student, also provide name of institution and graduation date)**	**F/T Student** Yes No	**Birth Date** Month	Day	Year

Is spouse employed? ☐ **Yes** ☐ **No** **If yes, please provide name of spouse's employer for coordination of benefits:** _____

Spouse's Social Security # _____ **Spouse Dental/Vision Insurance Carrier** _____

Fax to CM Regent Solutions at (866) 403-7701 or email to DVEnrollment@cmregent.com

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