PENNRIDGE SCHOOL DISTRICT

DISTRICT ADMINISTRATION OFFICE
1200 North Fifth Street • Perkasie, Pennsylvania 18944

HEALTH INSURANCE ENROLLMENT

☐ **New Enrollment** ☐ **Status Change** ☐ **Termination** ***(**must complete waiver form)***

Last Name: _____ First Name: _____ MI: _____ Gender: _____

Social Security #: _____ Home Phone: _____ Cell Phone: _____

Street Address: _____ City: _____

State: _____ Zip: _____ Birth Date: _____ Date of Hire: _____

I would like to enroll in the following coverages:

☐ Medical & RX: ☐ Employee Only ☐ Employee & Spouse ☐ Employee & Child ☐ Employee & Children ☐ Family

☐ Vision: ☐ Employee Only ☐ Family

☐ Dental: ☐ Employee Only ☐ Family | ***Dependents over the age of 19 must provide proof of full-time student status.*

MY DEPENDENTS/BENEFICIARIES ARE AS FOLLOWS:

First Name:		MI:		Last Name:	
Date of Birth		Social Security #:		Relationship:	
Other Address:		Medicare/Other Insurance Name /Policy #/Policy Holder:			

First Name:		MI:		Last Name:	
Date of Birth		Social Security #:		Relationship:	
Other Address:		Medicare/Other Insurance Name /Policy #/Policy Holder:			

First Name:		MI:		Last Name:	
Date of Birth		Social Security #:		Relationship:	
Other Address:		Medicare/Other Insurance Name /Policy #/Policy Holder:			

First Name:		MI:		Last Name:	
Date of Birth		Social Security #:		Relationship:	
Other Address:		Medicare/Other Insurance Name /Policy #/Policy Holder:			

First Name:		MI:		Last Name:	
Date of Birth		Social Security #:		Relationship:	
Other Address:		Medicare/Other Insurance Name /Policy #/Policy Holder:			

Employee Signature _____ Position/Building _____ ID# _____ Date _____

Below is for HR use only:

	Effective Date:	Sungard entry date	Vendor Entry Date
MEDICAL:			
RX:			
VISION:			
DENTAL:			