



City of San Antonio

2009 Employee Benefits Uniformed Change Form

1. EMPLOYEE INFORMATION	SAP #:
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Last:	First:	M.I.:
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Home Address:

City:	State:	Zip:
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SSN:	Date of Birth:	Male <input type="checkbox"/> Female <input type="checkbox"/>
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Date of Hire:	Department:	Work Phone Number:
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Emergency Contact Name:	Phone:	Relationship:
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2. Reason For Change (if past 31 days, employee must wait until annual enrollment to make the change.)

Date of Event: _____

Birth Certificate (to add newborn)
 Court Order for an Adoption of a child (to add dependent)
 Marriage License (to add new spouse)
 Certificate of Coverage (to add/drop dependent)
 Court Order (to add/drop dependent)
 Student Verification form, if school age (to add dependent)
 Death Certificate (to drop dependent)

3. In the left column select the coverage currently in force. Any changes in this coverage level should be indicated in the right column.

Current Medical Plan:

<input type="checkbox"/> CitiMed Uniformed Plan	<input type="checkbox"/> EE Only <input type="checkbox"/> EE + Child(ren) <input type="checkbox"/> EE + Spouse <input type="checkbox"/> EE + Family OR: <input type="checkbox"/> Waiver of Medical Coverage
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4. Current Dental Plan

<input type="checkbox"/> Pre-Paid Dental/Vision	<input type="checkbox"/> EE Only <input type="checkbox"/> EE + Child(ren) <input type="checkbox"/> EE + Spouse <input type="checkbox"/> EE + Family OR: <input type="checkbox"/> None
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5. List Dependents Changes (only those to be added or dropped)

Full Name	Relationship	Social Security #	Sex	Birth Date	Add or Drop
					<input type="checkbox"/> <input type="checkbox"/>
					<input type="checkbox"/> <input type="checkbox"/>
					<input type="checkbox"/> <input type="checkbox"/>
					<input type="checkbox"/> <input type="checkbox"/>
					<input type="checkbox"/> <input type="checkbox"/>
					<input type="checkbox"/> <input type="checkbox"/>

Are any of these dependents covered under another group plan, HMO, Medicaid or Medicare? Yes No

If yes, provide the information requested below or submit a photocopy of the insurance policy's membership card.

Insured Name	Insurance Company Name & Address	Member Number

7. Employee Authorization

I understand I have 31 days from the effective date of a Qualifying Event to notify Employee Benefits. All allowable changes will become effective on the effective date of the Qualifying event. I acknowledge that all payroll deductions related to these changes will be automatically deducted from my gross salary on a pre-tax basis. I understand that I cannot change or revoke my coverage options unless I have a change of status consistent with IRS Section 125 guidelines or during annual enrollment for the following year.

Signature of Employee:	Date:
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