Employee Enrollment/Change Form

☐ Open Enrollment

☐ New Employee

☐ Change (complete change section)

BOON-CHAPMAN

Benefits Administered by:
Boon-Chapman Administrators
P O Box 9201 Austin, TX 78766
Telephone - 800-936-7689
Fax - 800-213-7520

EMPLOYER NAME	GROUP NUMBER	EMPLOYEE JOB LOCATION (CHECK ONE)
SAN ANTONIO POLICE OFFICERS AND FIREFIGHTERS BENEFIT PLAN & TRUST	597	☐ 002 – POLICE ☐ 003 – FIREFIGHTER ☐ 004 – NON-UNIFORMED

EMPLOYEE START DATE	EFFECTIVE DATE OF COVERAGE

SOCIAL SECURITY NUMBER

NAME: LAST FIRST M.I.

ADDRESS CITY STATE ZIP

EMAIL ADDRESS

DATE OF BIRTH (MM/DD/YYYY)	GENDER	MARITAL STATUS	HOME TELEPHONE NUMBER
			( )

Do you or any family member currently have other dental/vision coverage? ☐ Yes, Single ☐ Yes, Family ☐ No

If yes to the above question, complete the following: Person's name _____

Employer Name _____ Carrier Name _____

Plan Number _____

DENTAL/VISION PLANS ☐ EMPLOYEE ☐ EMPLOYEE/FAMILY

☐ D01/V01 – ACTIVE POLICE

☐ D02/V02 – ACTIVE FIREFIGHTER

☐ D03/V03 – ACTIVE NON-UNIFORMED

IF YOU ARE ELECTING OR CHANGING ANY OF THE ABOVE COVERAGES, PLEASE COMPLETE THE REMAINING SECTIONS OF THIS FORM ON THE REVERSE SIDE.

COMPLETE THIS SECTION IF ELECTING DEPENDENT COVERAGE

First	MI	SS#	Birth Date	Gender	Relationship To Employee	Does this child reside with you?	Does this dependent qualify as an exemption for Federal Income Tax purpose?	Do you Provide More than 50% support?
Spouse Name			/ /					
Child Name								
1.			/ /					
2.			/ /					
3.			/ /					
4.			/ /					
5.			/ /					

Indicate any dependent children listed above who are 19 or older and are full-time students. Please complete the questions below for student status.

1. Is this dependent a full-time student? _____
2. Is this dependent a full-time student and on a medically-necessary leave of absence from school? _____
3. If the answer is yes to #2, what date did the medical leave begin? _____
4. How many credits and what semester is the dependent child registered for? _____
5. What is the actual or anticipated graduation date? _____
6. What is the school name? _____

COMPLETE THIS SECTION IF MAKING CHANGES

Please specify change and update in appropriate section.

Effective date of change: _____

☐ Employee name change

☐ Employee address change

☐ Other Coverage Change

☐ Date of Marriage_____

☐ Date of Divorce_____

☐ Other _____

☐ Eligible for Medicaid/CHIP subsidy

☐ Loss of Eligibility for Medicaid/CHIP subsidy

☐ Add dependents

☐ Remove dependents (list names)_____Reason:_____

☐ Add coverage DUE TO Qualifying Event (list reason):_____

Employee Signature Required_____

☐ Employment Termination: Reason:_____Last day worked _____Date coverage termed_____

I hearby certify that all of the above information is true and correct. I understand that coverage will not be effective until all questions regarding eligibility for coverage have been satisfactorily resolved. I understand that I may not change the coverage elections that I make on the Employee Enrollment/Change Form until the plan's next open/annual enrollment period or unless otherwise permitted by the Plan. Please refer to your Employee Benefit Booklet for specific detail of your benefit plan.

I hearby apply for coverage and authorize deductions from my earnings for the amount requested, if any, to cover any contribution for coverage.

Employee Signature _____ Date _____