Dental & Vision Enrollment/Change/Term & Transfer Form

RESIG
REDWOOD EMPIRE SCHOOLS' INSURANCE GROUP
Serving Schools Since 1979

Section A: For District Office Use Only

District Name: _____ Dental Group/Divison#: _____ Vision Group/Division#: _____

EE Classification: □ Classified □ Certificated □ Management/Confidental Date of Hire: Effective Date:

Terminations & Transfers

□ Terminate or □ Transfer EE: _____ □ Dental □ Vision Effective Date _____ SSN: _____ Transfer to: _____

□ Terminate or □ Transfer EE: _____ □ Dental □ Vision Effective Date _____ SSN: _____ Transfer to: _____

□ Terminate or □ Transfer EE: _____ □ Dental □ Vision Effective Date _____ SSN: _____ Transfer to: _____

Notes (Transfers from other Districts, Changes or Corrections, etc)

Section B: Event

□ New Enrollment □ Add Dependent(s) □ Delete Dependent(s) □ Terminate Coverage □ Change of Address □ Update or Correct Name, DOB or SSN

Section C: Enrollee

Name (Last, First, MI): _____ SSN: _____ Date of Birth: 06051999

Phone #: _____ Sex: □ Male □ Female □ Non-Binary Email Address: _____

Address: _____ City, State & Zip: _____

Section D: Dependents

			Sex	Dental	Vision
Spouse/Domestic Partner Name (Last, First, MI):	Date of Birth:	SSN:	□ Male □ Female □ Non-Binary	□ Add □ Delete	□ Add □ Delete
Child Name (Last, First, MI):	Date of Birth:	SSN:	□ Male Female □ Non-Binary	□ Add □ Delete	□ Add □ Delete
Child Name (Last, First, MI):	Date of Birth:	SSN:	Male □ Female □ Non-Binary	□ Add □ Delete	□ Add □ Delete
Child Name (Last, First, MI):	Date of Birth:	SSN:	Male □ Female □ Non-Binary	□ Add □ Delete	□ Add □ Delete
Child Name (Last, First, MI):	Date of Birth:	SSN:	□ Male □ Female □ Non-Binary	□ Add □ Delete	□ Add □ Delete
Child Name (Last, First, MI):	Date of Birth:	SSN:	□ Male □ Female □ Non-Binary	□ Add □ Delete	□ Add □ Delete

Section E: Signature

All information on this form is correct and true to the best of my knowledge. I understand that it is the basis on which coverage may be issued under the plan. Any misstatements or omissions may result in future claims being denied and/or the policy being rescinded. You are entitled to a copy of this signed authorization for your files.

I, on behalf of myself and my family members listed on this Form, if any, agree to be bound by the benefits, co-payments, deductibles, exclusions, limitations, and other terms and conditions of the Dental and Vision plan documents, including the Evidence of Coverage.

Additionally, any person who knowingly and with intent to injure, defraud, or deceive the district, RESIG, or plan service provider, by filing a statement or claim containing false or misleading information may be guilty of a criminal act punishable under law. I attest by signing below that I have reviewed the information provided on this application and to the best of my knowledge and belief, it is true and accurate with no omissions or misstatements.

Employee Signature: _____ Date: _____

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