# Los Angeles Unified School District
# Benefits Administration
# REQUEST FOR CHANGE OF DEPENDENT STATUS
# ACTIVE EMPLOYEES

| Employee Number | Last Name | First Name | M.I. |
|---|---|---|---|
| | | | |

| Address | City | State | Zip Code | Phone Number |
|---|---|---|---|---|
| | | | | |

| Social Security Number | ☐ Active ☐ Retired | ☐ Male ☐ Female | *Do Not Write In Shaded Boxes* | **Eff. Date** | **Process Date** | **Initial** |
|---|---|---|---|---|---|---|
| | | | | | | |

**HEALTH PLANS (Please check the plans you are currently enrolled.)**

**MEDICAL**

☐ Anthem Blue Cross Select HMO ☐ Health Net HMO ☐ Medical Opt-Out Cash Back*
☐ Anthem Blue Cross EPO ☐ Kaiser Permanente HMO ☐ No Medical Coverage

**DENTAL**

☐ United Concordia Dental PPO ☐ DeltaCare® USA DHMO
☐ Western Dental DHMO Centers Only ☐ Western Dental DHMO Plan Plus ☐ No Dental Coverage

**VISION**

☐ EyeMed Vision Care ☐ VSP® Vision Care ☐ No Vision Coverage

**DEPENDENT INFORMATION (Attach additional pages if necessary)**

| Action | SSN | Last Name | First Name | MI | Relationship | Date of Birth | Sex | Eff. Date |
|---|---|---|---|---|---|---|---|---|
| ☐ Add ☐ Delete | | | | | ☐ Spouse ☐ Domestic Partner | | ☐ M ☐ F | |
| Reason: | | | | | Date: | | | |
| ☐ Add ☐ Delete | | | | | (Son, Daughter, etc) | | ☐ M ☐ F | |
| Reason: | | | | | Date: | | | |
| ☐ Add ☐ Delete | | | | | (Son, Daughter, etc) | | ☐ M ☐ F | |
| Reason: | | | | | Date: | | | |

**NOTE:** Coverage for eligible dependent(s) will begin effective the first day of the following month in which the form and required documentation are received. This application will not be accepted without documentation to verify dependent status. **See next page to determine documents needed.**

* If you enroll in the Medical Opt-out/Cash-Back Plan, you must attest annually that you and your eligible dependents have "minimum essential coverage" through a group health plan, and the minimum essential coverage is not individual market coverage through Covered California. Attestation form is available at benefits.lausd.net under the Active Employee Section of the "Forms and Publications" page.

Internal Use

Social Security Number is mandatory for all dependents. Newborn: Social Security # is required within 2 months.

Is your spouse/Domestic Partner a LAUSD employee? ☐Yes ☐No Employee #_____

April 20, 2020

**THIS FORM WILL NOT BE PROCESSED UNLESS SIGNED AND DATED**

I understand this election will remain in effect as long as I remain eligible, or until I make another election during an annual enrollment period. I hereby authorize any insurance company, organization, employer, hospital, physician, surgeon, or pharmacist to release any information requested to pay any claim under the plan selected. I understand that I am responsible for notifying the District of any change in the eligibility of my dependents and am responsible for premiums and claims incurred on behalf of ineligible dependents. I also understand that I must abide by the provisions of the plan in which I enroll and that any controversy between any HMO plan member and such HMO (including its agents, staff physicians, employees and providers) is subject to binding arbitration. I certify under penalty of perjury that the above information is true and is accurate to the best of my knowledge and belief.

| Applicant's Signature | | Date: |
|---|---|---|
| | | |



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# Instructions

In order to assist the District in ensuring that your eligible dependents are properly enrolled under your District-sponsored plan, please read and follow the instructions below.

- **Complete this form, being sure to list <u>all</u> dependents you wish to have added. If necessary, attach an additional sheet of paper to the form.**
  a. List birthdays and Social Security numbers for all dependents. Social Security numbers are mandatory. Social Security numbers for newborns must be provided within two (2) months.
  b. If your spouse/domestic partner is also a District employee/ retiree, please list his or her employee number.

- **Provide verification of dependent status for dependents as follows:**
  a. Spouse - attach a copy of your registered marriage certificate issued by the state. For new spouses, if a registered marriage certificate is received within 45 days of the marriage date, spouse will be covered effective the date of the marriage.
  b. Domestic Partner - complete Declaration of Domestic Partnership form (available from Benefits Administration) and submit the required documentation as outlined in Section II of the Declaration form or submit a copy of your registration with the State. If all of the required documentation is received by Benefits Administration by the 10th of the month, coverage will be effective the first of the following month.
  c. Natural children - attach a copy of official birth certificate for each child. For newborns, if verification of birth is received within 30 days of birth (complimentary hospital birth certificate is acceptable), the newborn will be covered back to date of birth. If submitted more than 30 days but less than 5 months, the newborn will be covered on the first of the month after the verification was received. After a child is 5 months, an official birth certificate is required.
  d. Stepchildren - for each child, attach a copy of the birth certificate and a copy of your registered marriage certificate (issued by the state), and a copy of your latest income tax return showing the child's dependent status.
  e. Guardianship/Adopted children - attach a copy of the document verifying legal custody. If you submit verification of guardianship/adoption within 30 days of the guardianship/adoption, coverage will begin on the date of guardianship/adoption. If submitted after 30 days, coverage will begin on the first of the month after the verification was received.
  f. If you are the legal guardian of a child, please attach a copy of the guardianship papers issued by the court.
  g. Disabled dependent - must meet the disability standards of the plan and must be enrolled prior to age 19, or the dependent child must be enrolled as a full time student prior to the disabling condition.

**DEPENDENTS FOR WHOM THE REQUIRED DOCUMENTATION IS NOT RECEIVED WILL NOT BE COVERED UNDER YOUR MEDICAL, DENTAL OR VISION PLAN(S) UNTIL THE APPROPRIATE DOCUMENTATION IS RECEIVED.**

**EFFECTIVE DATE OF ADDITIONS:**
Coverage will begin on the first day of the month following the receipt of the Request for Change of Dependent Status form along with the required verification. **Example:** If verification and the Enrollment form is received by Benefits Administration on January 1st, the dependent's enrollment becomes effective February 1st.

Visit http://benefits.lausd.net for the Optional Life Insurance Brochure for payroll deducted supplemental life insurance.

**TERMINATION OF COVERAGE:**
Coverage will be terminated on the last day of the month in which the employee or the dependents became ineligible.

**Complete and return this form along with copies of the required documents to:**

Los Angeles Unified School District - Benefits Administration
P.O. Box 513307
Los Angeles, CA 90051-1307
Fax: (213) 241-4247 Phone: (213) 241-4262
Email: benefits@lausd.net
Website: http://benefits.lausd.net