PLEASE PRINT THIS FORM AND SUBMIT IT TO THE DEPARTMENT OF HUMAN RESOURCES

Thompson School District Name Change Form

******IMPORTANT******

This form is only used to change your name with the Thompson School District. To change your name with PERA, please contact them directly at 1-800-759-7372 or at www.copera.org.

Name Change - If you are changing your name, please submit this form to **Human Resources** at the Administration Building, 800 S. Taft Avenue, and attach a copy of your social security card to verify your name. **We do not accept receipt for your social security card.**

***NOTE: Submission of this form will change your network login as well as your email account. Your old email address will become inactive within 12 hours of processing your request. We recommend that you notify your contacts ASAP.**

Insurance updating – If you carry the district insurance, please fill out page 2 of this form to change your name with CEBT. If you are adding/changing coverage for spouse/ dependent(s) due to a qualifying event (e.g., marriage/divorce, birth/adoption), you **MUST** notify the insurance department at 613-5004.

Please fill in the information below.

Employee ID#: _____

1. **Former Name**: _____
   Last Name (Please Print) First Name Middle Initial

2. **New Name**: _____
   Last Name (Please Print) First Name Middle Initial

Please provide us with a phone number below if we have any questions about this change.

Primary Phone: (_____) _____ **Alt. Phone**: (_____) _____

Signature: _____ **Date:** _____

******INTERNAL USE ONLY******

Insurance _____ HR Specialist _____ (IFAS) _____ (CDE) Sub Coordinator _____ Payroll _____

☐ New Enrollee
☑ Change of Enrollment
☐ Change of PRE or AFTER Tax Withholding

CEBT Enrollment / Change Card

Employer – Complete all shaded areas at the top of the card.

Name of employer	Date of Full Time Eligibility	Salary	Effective Date (Required)	Branch #
Thompson School District R2J				22

1. Employee's Name (last, first, middle initial)	2. Social Security #	3. Date of Birth

4. Employee's mailing address Street	City	State	Zip	5. Male ☐ Female ☐

6. Beneficiary's name	6a. Relationship to you	6b. Social Security #	6c. Date of Birth

Unless otherwise provided herein, if two or more beneficiaries are names, the proceeds shall be paid in equal shares to the named beneficiaries if surviving the insured, or the survivor of survivors. If no beneficiary survives, payment shall be made in accordance with the terms of the policy.

Withholding: ☐ Pre Tax ☐ After Tax Spouse employed at TSD? Yes ☐ No ☐

8.	PPOIV	PPOV	Kaiser	HRP	Dental	Vision	Life
Employee Only	☐	☐	☐	☐	***Packaged***	☐	☐
Employee & Spouse	☐	☐	☐		***with***	☐	☐
Employee & Child/ren	☐	☐	☐		***Medical***	☐	☐
Family	☐	☐	☐			☐	☐
(MPA Only)							

9. Do you want dependent coverage?

Last, First	Social Security Number (Required)	Date of Birth	Gender	Enrolled in Medicare?
1. Spouse			M ☐ F ☐	Yes ☐ No ☐
2. Dependent Child			M ☐ F ☐	Yes ☐ No ☐
3. Dependent Child			M ☐ F ☐	Yes ☐ No ☐
4. Dependent Child			M ☐ F ☐	Yes ☐ No ☐
5. Dependent Child			M ☐ F ☐	Yes ☐ No ☐

10. PLEASE CHECK ONE:

Add Spouse ☐ Effective Date_____ Marriage ☐ Drop Spouse ☐ Effective Date_____ Divorce ☐

Add Dependent(s) ☐ Drop Dependent(s) ☐ Beneficiary Change ☐ Name Change ☑ Address Change ☐

CEBT Hospital Reimbursement Plan (HRP) Acknowledgement

I have read, understand and agree that by enrolling in the CEBT Hospital Reimbursement Plan (HRP) that this coverage will be secondary. The HRP will only pay Benefits for unreimbursed eligible hospital expenses after my primary plan has processed the charges. The benefits under the HRP will be $1,000 per day, up to $30,000 calendar year maximum.

I have read and understand the benefits information provided and I, (a) authorize the elections I have made and the payroll deductions for any required payments (salary reductions) and (b) am aware that these elections are irrevocable for the Plan year unless I have an eligible change in family status, (c) understand that these elections will remain effective until I change them during future annual enrollment or when otherwise allowed by law and the program and should I fail to change my elections during a future enrollment period, I authorize the Thompson School District to deduct from my wages the corresponding deduction amount for the coverage level I have selected, (d) understand that this authorization will become effective on the first pay period after the insurance coverage effective date.

11. Employee's signature _____ Home Phone # _____ 12. Date signed _____

Print Name_____ Employee ID#_____

(Your typed name indicates your signature and request to add family members to your coverage).

FOR MPA USE ONLY				**COV. TYPE** (20)	**e** ☐	**s** ☐	**c** ☐	**f** ☐	
BENEFIT CLASSES (four digits)				**VOLUMES** *(if applicable, enter 1000 for DEP and/or DEP VLIF)					
EFFECTIVE DATE	**EE** (23 EE)	**SP** (23 SP)	**CH** (23 CH)	**Enrollee** (01)	***DEP** (Member 03)				