Washoe County School District
Group Benefit Programs

Employee ID #:

RETIREE CHANGE FORM

Last Name	First Name	MI	SSN	Effective Date of Change	Date of Birth

Address	City	State	Zip Code	Phone	Email Address

1. Delete Retiree Coverage: Medical / Dental _____ GAP _____ Vision _____ Basic Life _____ Sup Life _____

2. Delete Spouse or Dependent Coverage: Medical/Dental _____ GAP _____

3. Add Spouse or Dependent Coverage: Medical/Dental _____ GAP_____

4. Reason for Deleting or Adding Spouse / Dependents:

Divorce _____ Death _____ Marriage _____ Domestic Partnership _____ Loss of insurance _____ Enrolled in Other Coverage _____

5. Spouse / Dependent Information (**List only those dependents you are adding or deleting from coverage. If adding a Spouse or Dependent please provide a social security number and a marriage certificate, domestic partnership certificate, birth certificate or a recent tax document listing them as a spouse or dependent.)**

	Last Name	First Name	MI	Birthday	M/F	Social Security #
Spouse						
Child						
Child						
Child						
Child						

If deleting a dependent and COBRA needs to go to a different address, please list it here: _____

Employee/Retiree Certification:

With my signature, I hereby declare, certify, and state under penalty of perjury that the information I have provided here is true and correct, that the dependents listed above are eligible under my Employer's Dependent Benefit Criteria. Further, I understand that the information supplied, herein, may be used by my Employer in order to verify my dependent(s) for purpose of coverage, to make decisions about my coverage under my Employer's employee benefit plans and as otherwise necessary in connection with managing the organization's employee benefits plans. I understand that if the information I have provided is not true and correct, my dependent benefit coverage will be terminated.

Retiree Signature _____ Date Signed _____

Benefits Department USE ONLY:

Benefits Specialist signature:_____