GOLD COAST JOINT BENEFITS TRUST
ENROLLMENT AND CHANGE OF STATUS FORM

EFFECTIVE DATE
_____
FOR OFFICE USE ONLY

PARTICIPANT INFORMATION

School District: _____

Bargaining Unit/Union: _____

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Telephone: _____ Alt. Tele _____

Social Security Number: _____ Date of Hire: _____

Date of Birth: _____ Health Care ID #: _____

Sex: □ Male □ Female

Marital Status: □ Single □ Married □ Divorced □ Domestic Partnership

Emp. Status: □ Active □ Retiree □ COBRA

Classification: □ Certificated □ Classified □ Support □ Confidential □ Board □ Other □ Management

✓	CHECK ALL THAT APPLY
	New Enrollment
	Add Dependents _____ (If new marriage, give date married)
	Delete Dependents **Note: If you are terminating coverage of a dependent you must notify the District within 60 days or you may be liable for costs incurred by the Trust for ineligible dependent (s).**
	Name Change (Previous name)
	Address Change
	Reason for Change:

CHECK ONE EACH FOR MEDICAL, DENTAL, AND VISION	
MEDICAL	
□ Coverage _____ (Plan Name)	□ No Coverage
DENTAL	
□ Coverage	□ No Coverage
VISION	
□ Coverage	□ No Coverage

FOR NEW ENROLLMENT: List all eligible family members.
FOR CHANGES: List only dependents that you are adding or dropping from coverage.

To enroll your dependent(s), the following documents must be provided:

- ✓ For spouse: Copy of Certified Marriage Certificate
- ✓ For Domestic Partner: Copy of Declaration of Domestic Partnership certified by the Secretary of State
- ✓ For Children: Copy of Certified Birth Certificates
- ✓ For Adopted Child or Child placed for adoption: Copy of Court Adoption Documents or placement papers.

RELATIONSHIP	PERSON COVERED (Last Name, First and Initial)	SOCIAL SECURITY NUMBER	DATE OF BIRTH	DOES HE OR SHE HAVE OTHER COVERAGE?
□ Add □ Husband □ Drop □ Wife □ Dom. Part.				□ Yes □ No
	Address (If different from participant):			
□ Add □ Son □ Drop □ Daughter □ Other				□ Yes □ No
	Address (If different from participant):			
□ Add □ Son □ Drop □ Daughter □ Other				□ Yes □ No
	Address (If different from participant):			

For additional listing of children, obtain a Continuation of Additional Children Form from your School District

Note for enrolling Children: Children are eligible for coverage only until age 26. Your child's coverage will end the last day of the month in which your child reaches age 26.

I declare under penalty of perjury under the laws of the State of California, that all information on this form is current and accurate. I will immediately notify the Trust in writing if there is ever a change in the eligibility status of any dependent listed on this form (e.g., in the event of a divorce or dissolution of domestic partnership). I understand that if I decline enrollment when I am first eligible and wish to enroll at a later date, my enrollment will not be allowed until my District's next Open Enrollment period. By signing this Enrollment and Change of Status Form, I am agreeing to have any dispute with the Gold Coast Joint Benefits Trust, its Agents and their employees regarding a claim for benefits decided by a neutral arbitration. I am giving up my right to jury or court trial and agreeing to a reduced period of limitations in which to initiate my claim.

Your Signature: _____ Date: _____

► PLEASE RETURN THIS FORM TO YOUR SCHOOL DISTRICT OFFICE ◄

WHITE – TRUST ADMINISTRATOR'S COPY YELLOW-DISTRICT'S COPY #1 PINK-DISTRICT'S COPY #2 GOLDENROD-MEMBER'S COPY