

CHANGE OF STATUS FORM (PCSB)

INSTRUCTIONS: COMPLETE SECTION, WHICH APPLIES TO DESIRED CHANGE.

PLEASE PRINT OR TYPE.

EMPLOYEE NAME

SOCIAL SECURITY NUMBER

SAP#

WORK LOCATION NAME

2. I AM ADDING DELETING

REASON:

- | | | | | |
|--|--|--|------------------------------------|---|
| <input type="checkbox"/> MEDICAL | <input type="checkbox"/> AMER/HERI/CAN/ACC | <input type="checkbox"/> MARRIAGE | <input type="checkbox"/> DIVORCE | <input type="checkbox"/> LEGAL ADOPTION |
| <input type="checkbox"/> DENTAL | <input type="checkbox"/> OPT. LIFE | <input type="checkbox"/> BIRTH | <input type="checkbox"/> STEPCHILD | <input type="checkbox"/> DEATH |
| <input type="checkbox"/> AIG (EM.CARE INS.) | <input type="checkbox"/> SHORT TERM DIS | <input type="checkbox"/> LEGAL GUARDIANSHIP | | |
| <input type="checkbox"/> AIG (CRITICAL ILLN) | <input type="checkbox"/> LONG TERM DIS | <input type="checkbox"/> COMMENCEMENT/TERMINATION OF EMPLOYMENT | | |
| <input type="checkbox"/> AIG (UNV. LIFE) | <input type="checkbox"/> VISION | <input type="checkbox"/> OVER AGE DEP/NOT STUDENT/NO LONGER IN HOUSEHOLD | | |
| <input type="checkbox"/> FSA | | | | |

OTHER, PLEASE SPECIFY _____

REASON: Must be a lifestyle change with supporting documentation and be within 30 days of event. DATE YOU WISH THE COVERAGE TO BEGIN/END (circle one) / /

LAST NAME	FIRST	MI	SEX M/F	SOCIAL SECURITY # Not necessary if newborn	BIRTHDAY M/D/Y
SELF:					
SPOUSE:					
CHILD:					
CHILD:					
CHILD:					
CHILD:					

PLEASE INDICATE IF CHILD IS A DEPENDANT OF A DEPENDANT: YES NO

I understand that the favorable tax treatment under the School Board of Polk County is dependent on my giving accurate statements on this form. A false statement may cause my benefits and the benefits of all School Board of Polk County employees to become taxable income. Knowing this, I hereby certify that the event(s) described above (will occur)(occurred) on the indicated date.

EMPLOYEE SIGNATURE

DATE:

EMPLOYER SIGNATURE

DATE:

(THIS LINE IS FOR RISK MANAGEMENT USE ONLY)

EFFECTIVE DATE:

Please return completed form via courier to:

**Ins. Dept.-District Office, Route E
Or
PSCB, P.O. BOX 391, BARTOW, FL 33831
ATTENTION: RISK MANAGEMENT**