Covina-Valley Unified School District Payroll Authorization

Employee Name (First, MI, Last)	DOB	Employee SS#	Contact #	Gender
				☐ M ☐ F

Address	Job Title	School/Dept.
	☐ 20-30hr. Classified employee	

For Office Use Only (Do not write in this section)		
☐ New employee Hire Date: ___________________ ☐ Open Enrollment ☐ Add Newborn DOB: ___________________ ☐ Name Change Former name: ________________ ☐ Job Share (See back of form) ☐ Delete Dependent (See back of form) ☐ Other QE ___________________ Date: ___________________	Hire Date: ___________________ Benefit Begin Date: ______________ Hard Cap EXEMPT: ☐ Yes ☐ No Job Class: ___________________ EID: ___________________ Entered by: ___________________ Date Entered: ________________	**Dependent/QE Documentation:** ☐ Tax Form ☐ Marriage Affidavit ☐ Marriage Certificate ☐ Birth Certificate(s) ☐ Hospital Birth Record ☐ Adoption Court Order ☐ Divorce Decree ☐ Loss/Proof of Other Coverage ☐ Other: ___________________

District Benefit Plans

Medical	Dental	Vision	Basic Life Insurance	Supplemental Life Insurance
☐ Blue Shield PPO ☐ Blue Shield Access +HMO ☐ Blue Shield Trio HMO ☐ Kaiser HMO ☐ Waive Medical coverage* **$100 cash added to tenthly pay warrants**	☐ Delta Dental PPO ☐ MetLife/Safeguard DHMO ☐ Waive Dental coverage	☐ VSP ☐ Waive Vision coverage	☐ $30k Voya Basic Term Life & AD&D (District Paid)	**☐ Voya Voluntary Term Life** ☐ Employee $____________ ☐ Spouse $____________ ☐ Child(ren) $____________ **☐ Voya Voluntary Term AD&D** ☐ Employee $____________ ☐ Spouse $____________ ☐ Child(ren) $____________

** I understand that should I elect to enroll myself or family members in a District-Sponsored medical plan at a later date enrollment will be subject to all of the rules in effect, including the submission of appropriate health statements and furnish any and all dependent verification documents.*

Voya Beneficiary Information (All fields required)

Voya Beneficiary Name	Relationship	Gender	Contact #	SS#	DOB
		☐ M ☐ F			
Address:					

Dependent Enrollment Information (All fields required for each covered dependent)

Dependent Name (First, MI, Last)	Relationship	Gender	DOB	SS#	MEDICAL	DENTAL	VISION	VOLUNTARY LIFE	VOLUNTARY AD&D
		☐ M ☐ F			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
		☐ M ☐ F			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
		☐ M ☐ F			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
		☐ M ☐ F			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
		☐ M ☐ F			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
		☐ M ☐ F			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

I have selected medical, dental, and vision coverage as indicated above and hereby authorize the district to make appropriate payroll deductions for any coverage selected. Such deductions shall not exceed that amount agreed to by my exclusive representative as approved by the Board of Education. I understand that this authorization includes any increases, decreases, or discontinuance to coincide with these changes and will remain in effect until canceled in writing by me. I further understand that insurance canceled by me ends on the last day of the month for which premiums have been paid.

Signature of employee:____ **Date:**________________________________

Job share option

☐ I am assigning District-paid medical benefits to my job share partner.

☐ I am receiving District-paid medical benefits from my job share partner.

☐ I am opting to split the District assigned medical benefits to with my job share partner. I agree to contribute the balance of the cost of the selected medical plan in accordance with the inverse percent of our assignment as indicated below.

School Site: ______________________________________

Job Share Partner #1 Name: ___________________________ Percentage:	Job Share Partner #2 Name: ___________________________ Percentage:

Cancelling Coverage for Dependents

☐ I am cancelling dependent(s) coverage in the following plans:

Medical	Dental & Vision	Life Insurance
☐ Blue Shield PPO	☐ Delta Dental PPO	☐ Voya Voluntary Term Life & ADD
☐ Blue Shield Access +HMO	☐ MetLife/Safeguard DHMO	☐ Employee
☐ Blue Shield Trio HMO	☐ VSP	☐ Spouse
☐ Kaiser HMO		☐ Dependent Child(ren)

Federal Public Law 99-272, Title X (COBRA) provides that covered employees are eligible for benefit extensions if they terminate, if their dependent(s) become ineligible because of age or marriage, or if they are divorced or legally separated. These employees and their enrolled dependents have the right to pay for continued coverage in the medical, dental, and vision care plans under certain circumstances.

Last Name	First Name	Relationship	SS#	DOB	Gender
					☐ M ☐ F
Address:					
Reason for Cancellation:			**Date:**		

Last Name	First Name	Relationship	SS#	DOB	Gender
					☐ M ☐ F
Address:					
Reason for Cancellation:			**Date:**		

Last Name	First Name	Relationship	SS#	DOB	Gender
					☐ M ☐ F
Address:					
Reason for Cancellation:			**Date:**		

Last Name	First Name	Relationship	SS#	DOB	Gender
					☐ M ☐ F
Address:					
Reason for Cancellation:			**Date:**		

Employee Signature: ____ **Date:**______________________________