ADD DEPENDENT

EMPLOYEE:_____ ASSOCIATION:_____

Qualifying Event (Please check one):

☐ Marriage or Registration of Domestic Partnership* (Date:_____)
☐ Birth of child (Date:_____)
☐ Adoption* (Date:_____)
☐ Loss of Coverage* (Date:_____)
☐ Other*: _____ (Date:_____)

**Please attach supporting documentation such as marriage certificate, etc.*

Add Dependent:

1. Name of Dependent:_____
   Relationship:_____ Date of Birth:_____
   Social Security Number:(required for spouse only)_____
   Add to (please check all that apply): ❒ Medical ❒ Dental ❒ Vision
   *(For BS HMO, indicate physician and medical group:*_____

2. Name of Dependent:_____
   Relationship:_____ Date of Birth:_____
   Social Security Number:(required for spouse only)_____
   Add to (please check all that apply): ❒ Medical ❒ Dental ❒ Vision
   *(For BS HMO, indicate physician and medical group:*_____

3. Name of Dependent:_____
   Relationship:_____ Date of Birth:_____
   Social Security Number:(required for spouse only)_____
   Add to (please check all that apply): ❒ Medical ❒ Dental ❒ Vision
   *(For BS HMO, indicate physician and medical group:*_____

Name Changes

If you have a name change, you must submit a copy of your social security card (indicating the new name) and complete an Employee Address and Name Change form.

Beneficiary Changes

If you would like to change your beneficiary designations for the following plans, please check the appropriate boxes and the appropriate forms will be requested and sent to you through interoffice mail.

❒ CalPERS (retirement)
❒ Last Checks/Warrants Beneficiary
❒ Standard Insurance (Life, AD&D, optional life)
❒ Emergency Contact Information

_____ _____
Employee Signature Date