Greater Johnstown School District

Insurance Change Form

Name: _____Job Title: _____
(Please print)

Effective Date: _____

As an employee of the Greater Johnstown School District (District), there are several options available to you. In order to be sure each employee has a proper understanding of these options, please carefully read and complete this form. **Write your initials** on the lines that correspond to the appropriate responses in the applicable areas.
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HEALTH INSURANCE:

_____ I would like to make a change to my current Health Insurance Plan.

(circle plan choice):

CDPHP MVP EMPIRE –PPO- B Low EMPIRE PPO-B High EMPIRE EPO Empire EPO w/HSA

Individual 2 Person Family

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DENTAL INSURANCE:

_____ I would like to make a change to my current Dental Insurance Plan.

(circle plan choice):

Delta Dental Options:

HIGH- Individual Employee/Spouse Employee/Child Family

LOW- Individual Employee/Spouse Employee/Child Family

CSEA Dental Options:

Individual 2 Person Family

**Delta Dental plans have changed for the 23/24 school year. Please review plan options on our district website*.*

Greater Johnstown School District

Dependent Information/Questionnaire

Dependent's Name: ____

DOB: ____________________

SSN: ____________________

Tobacco User: YES/ NO

Full-Time College Student: YES/ NO

Dependent's Name: ____

DOB: ____________________

SSN: ____________________

Tobacco User: YES/ NO

Full-Time College Student: YES/ NO

Dependent's Name: ____

DOB: ____________________

SSN: ____________________

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