Reset Form

Print Form

ENROLLMENT & CHANGE FORM

City of Shreveport
Benefits Office
PO BOX 31109
Shreveport, LA 71130-1109

Phone Number: 318 - 673 - 5420

Select one of the following:

- ☐ Late Entrant
- ☐ New Hire
- ☐ Add Dependent (Marriage)
- ☐ Add Dependent (Adoption)
- ☐ Add Dependent (Newborn)
- ☐ Add Dependent (Other)
- ☐ Change in Beneficiary(ies)
- ☐ Address Change
- ☐ Cancel Dependent (Divorce)
- ☐ Cancel Dependent (Death)
- ☐ Cancel Dependent (Age Limit)
- ☐ Cancel Dependent (Other)
- ☐ Terminate Medical Coverage
- ☐ Terminate Dental Coverage
- ☐ Terminate Life Coverage

PERSONAL INFORMATION

LAST NAME	FIRST NAME	MI	DATE OF BIRTH	SSN

ADDRESS	CITY	STATE	ZIP
		Louisiana	

In case we need to contact you:

Other Number which we may use:

Home Phone (include area code):

SEX
- ☐ Male
- ☐ Female

MARITAL STATUS
- ☐ Married
- ☐ Single
- ☐ Widow

ACTIVE EMPLOYMENT:
Department:
Hire Date:
Annual Salary:

RETIREMENT DATE:
Date:

☐ **DECLINE OPTION**

I decline this opportunity to participate in the Medical, Dental or Life insurance plans offered by the City of Shreveport. If you decline all benefit participation, do not answer any more questions. Please check the box 'DECLINE OPTION' at the left, then sign this form and return this original form to the Benefits Office.

Select Desired Coverage:

EMPLOYEE:	SPOUSE:	CHILDREN:	**Effective Date:**
☐ MEDICAL	☐ MEDICAL	☐ MEDICAL	
☐ DENTAL	☐ DENTAL	☐ DENTAL	
☐ LIFE	☐ LIFE	☐ LIFE	

Check One: ☐ **Initial Coverage** ☐ **Add(ing) Dependents** ☐ **Cancel(ing) Dependent(s)**

Please List: **Name** **Address** *** Relationship** **SSN** **Sex** **Date Of Birth**

Spouse:

Child:

Child:

Child:

* Son, Daughter, Step-son, Step-Daughter, Foster Child, Etc.

IF YOU ELECTED GROUP LIFE, INDICATE BENEFICIARY(IES) : Check One: ☐ **Add(ing) Beneficiary(ies)** ☐ **Cancel(ing) Beneficiary(ies)**

	Beneficiary(ies) Name	Address	Relationship	SSN	Phone #
1.					
2.					
3.					

Other Insurance:

Are you covered by other Insurance? ☐ **Yes** ☐ **No** (If yes, a copy of the Insurance Card is required)

Retiree Medicare:

Plan: ☐ **A** ☐ **B** ☐ **A & B** No. _____ **Spouse Medicare:** ☐ **A** ☐ **B** ☐ **A & B** No. _____

If you desire to reduce your Federal taxes by reducing your gross pay by the amount of your premiums, **you must complete** a separate **Pre-Tax Benefit Form**.

After completion, please sign and return this original form and required documents to the Benefits Office.

EMPLOYEE/RETIREE SIGNATURE: **DATE:**