***PARKWAY SCHOOL DISTRICT***

***ATTN: BENEFITS DEPARTMENT***

***455 NORTH WOODS MILL ROAD***

***CHESTERFIELD, MO 63017***

 **OPEN ENROLLMENT CHANGE FORM *(314) 415-8059***

**RETIREE/COBRA/LOA/SURVIVING DEPENDENT**

**01-01-24 TO 12-31-24**

**DENTAL AND/OR VISION ONLY**

**Any Questions Email Janet at:** **jbovaconti@parkwayschools.net**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_*XXX-XX-\_*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LAST NAME, FIRST NAME SOCIAL SECURITY NUMBER (LAST FOUR ONLY)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

STREET ADDRESS DATE OF BIRTH

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SEX: M\_\_\_\_\_\_ F\_\_\_\_\_\_

CITY, STATE, ZIP CODE

EMAIL ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE NO:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IF YOU ARE NOT MAKING ANY CHANGES TO YOUR BENEFITS AT THIS TIME, NOTHING NEEDS TO BE RETURNED TO THE FINANCE/BENEFITS OFFICE. DENTAL AND VISION PREMIUMS ARE THE SAME FOR PLAN YEAR 2024.**

I WOULD LIKE TO SWITCH FROM SUNLIFE ASSURANT DENTAL TO THE DELTA DENTAL PLAN \_\_\_\_\_\_\_\_

I WOULD LIKE TO SWITCH FROM DELTA DENTAL PLAN TO SUNLIFE ASSURANT DENTAL PLAN \_\_**N/A**\_

(Parkway is not allowing any NEW enrollees to Assurant Dental in 2024)

I WOULD LIKE TO ENROLL IN THE EYEMED VISION PLAN**\*\***  \_\_\_\_\_\_\_\_

I WOULD LIKE TO ADD THE FOLLOWING DEPENDENTS TO MY CURRENT 2024 PLAN **\*\*** \_\_\_\_\_\_\_\_

(Please list all dependents you are adding to the below grid. D = Dental, V = Vision)

I WOULD LIKE TO DROP THE FOLLOWING FROM MY CURRENT 2024 PLAN \_\_\_\_\_\_\_\_

(Please list yourself or any dependents that you are dropping on the below grid. D=Dental, V=Vision)

\*\* You can only add yourself or dependents if you are within one year from your retirement date.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| RELATIONSHIP | GENDER M/F | LAST NAME | FIRST NAME | BIRTH DATE | SOCIALSECURITYNUMBER |  | D | V |
| SELF |  |  |  |  |  |  |  |  |
| SPOUSE |  |  |  |  |  |  |  |  |
| CHILD |  |  |  |  |  |  |  |  |
| CHILD |  |  |  |  |  |  |  |  |

RETIREE/COBRA/LOA SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE**\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Sign if making changes to your account.

Once you drop your Parkway medical, dental or vision benefits; you cannot re-enroll at a future time.