Akron Public Schools

AKRON PUBLIC SCHOOLS
Group Health Benefit Information Form

Employee ID # _____ SSN# _____ Job Position _____

EMPLOYEE NAME: _____
LAST FIRST MI

DATE OF BIRTH: _____ GENDER _____ M F _____
Month Day Year

PHONE NUMBER ( ) _____

FAMILY STATUS Single ☐ Married ☐ Date:____ Divorced ☐ Date:____ Widowed ☐

The information below will be used for your benefit system log-in

EMAIL ADDRESS: _____ MOTHER'S MAIDEN NAME: _____

SPOUSE _____
LAST FIRST MI

DATE OF BIRTH ____/____/____ SSN # _____

EMPLOYER: _____

Please complete the information below for ALL dependents that you intend to elect coverage for.

Children Under 19 Years of Age
Attach additional pages if necessary.

Name	Relationship	Gender	DOB	SSN #
				____/____/____
				____/____/____
				____/____/____
				____/____/____

Children 19 and Older (**NOT** CURRENTLY A FULL-TIME STUDENT)

Name	Relationship	Gender	DOB	SSN #
				____/____/____
				____/____/____
				____/____/____
				____/____/____

Children 19 and Older --FULL-TIME STUDENT

Name	Relationship	Gender	DOB	SSN #
				____/____/____
Name of School Currently Attending			____/____/____ Expected Date of Graduation	

Name	Relationship	Gender	DOB	SSN #
				____/____/____
Name of School Currently Attending			____/____/____ Expected Date of Graduation	

Employee Signature _____ Date _____ Building Location _____

FOR BENEFIT OFFICE USE ONLY:	Notes:
_____ New Hire _____ Munis/Deduct.	
_____ Open Enrollment _____ COBRA	
_____ Status Change _____ EMB	