Health Form Plan Information Update

SisCo — Experience the Benefits

SECTION I – EMPLOYEE INFORMATION AND COVERAGE					
Name (First, MI, Last)			Email Address		
Address (Street, City, State, Zip)			Telephone (Home and Cell)		Alternate or Preferred Number?
Marital Status	❑ Married	❑ Single	❑ Divorced	❑ Legally Separated	❑ Widow/Widower
Audit Number/Web Log-In:	Employee Sex: ❑ Male ❑ Female		Employee Date of Birth	Division:	

SECTION II – DEPENDENT INFORMATION				
Name (First, MI, Last)	Relationship	Social Security # *The collection of SSN for all dependents is required*	Date of Birth	Gender
Spouse ***(Marriage Certificate and 2024 tax return listing filing status)***	❑ Spouse			❑ M ❑ F
Dependent ***(Birth Certificate (listing parent's names)***	❑ Natural/Adopted ❑ Stepchild ❑ Foster Child ❑ Other			❑ M ❑ F
Dependent ***(Birth Certificate (listing parent's names)***	❑ Natural/Adopted ❑ Stepchild ❑ Foster Child ❑ Other			❑ M ❑ F
Dependent ***(Birth Certificate (listing parent's names)***	❑ Natural/Adopted ❑ Stepchild ❑ Foster Child ❑ Other			❑ M ❑ F
Dependent ***(Birth Certificate (listing parent's names)***	❑ Natural/Adopted ❑ Stepchild ❑ Foster Child ❑ Other			❑ M ❑ F

SECTION III – LEGAL PROVISIONS For dependents listed in section II

1) Do your spouse and all enrolled children reside with you more than 6 months of the year?	❑ Yes	❑ No	If not, list who does not;

2) Does a divorce decree/court order assign responsibility for health coverage or grant tax exemption rights for any enrolled dependent? Note this responsibility/right may be assigned to you or your spouse. It may also be assigned to the ex-spouse of you or your spouse.

☐ Yes, a legal order exists with one of these parties. *If YES, attach a copy of the Decree or Court Order to this form*

☐ No order exists

SECTION IV – SIGNATURE TO VERIFY ACCURACY

The above information is complete and true to the best of my knowledge. I understand that falsification by me will allow the Plan Administrator to recover payments made, cancel my coverage, and/or refuse payment of claims.

Employee Signature	*Date*