SEQUOIA UNION HIGH SCHOOL DISTRICT

Employee Enrollment and/or Change Form

Full Name: _____

Last *First* *M.I.* *Date of Birth*

Address: _____

Street Address *City* *State* *ZIP Code*

_____

Phone # *Hire Date*

Status:
☐ Certificated ☐ Classified
(Please check one)

Purpose:
☐ New Hire ☐ New Changes

CLASSIFIED EMPLOYEES ONLY

Basic Life and AD & D Insurance: Provided at no cost (after completion of probation, eligible employee must work 20 hours or more per week) Effective Date:_____

Long Term Disability (LTD) Insurance: Provided at no cost (after one month of continuous employment of 25 hours or more per week) Effective Date:_____

Beneficiary Designation: When naming more than one beneficiary, list what percent of the benefit should go to each to equal 100%.

Primary Beneficiary

Name #1_____ Relationship_____ Phone # _____ %_____

Name #2_____ Relationship_____ Phone # _____ %_____

Contingent Beneficiary

Name #1_____ Relationship_____ Phone # _____ %_____

Name #2_____ Relationship_____ Phone # _____ %_____

I hereby appoint the above named as beneficiaries on my SHUSD Life Insurance.

Signature: _____ **Date:** _____