Shawn Judson, Ed.D.
Superintendent
Douglas M. Claflin
Assistant Superintendent of Business Services
Terry Embleton
Assistant Superintendent of Personnel Services
Charlayne Sprague
Assistant Superintendent of Instruction/Pupil Services

6061 East Avenue, Etiwanda, California 91739
www.etiwanda.k12.ca.us
(909) 899-2451 FAX (909) 803-3029

Health Insurance Verification Form

YOUR INFORMATION	
ESD Employee Name (LAST NAME, FIRST NAME, M.I.)	
Position	LAST 4 DIGITS SSN XXX – XX –

Please submit this form to the address or fax number listed above

Following information must be completed by Spouse's Employer:

SPOUSE INFORMATION			
Spouse Name (Last Name, First Name, M.I.)			
Employer Name			
Employer Address			
Name of Medical Insurance Carrier		**Policy Number**	
Effective Dates of Coverage	**Dependent No.1**	**Dependent No.2**	
Dependent No.3	**Dependent No.4**	**Dependent No.5**	
Employer Representative Signature	**Phone Number**	**Date**	
Employer Representative Name (Please Print)	**Employer Representative Title**		

I certify that the information provided above is accurate and true to the best of my knowledge. In order to validate information, Etiwanda School District may conduct audits and/or contact the employer listed. It is fraudulent to fill out this form with any information that is known to be false and/or to omit facts. Providing false information may result in disciplinary action and/or denial of covered benefits. I understand that it is MY responsibility to notify the Payroll & Benefits Dept. within 31 days should any of the information provided on this form change.

_____ _____

ESD Employee Signature Date

For questions, please contact the Benefits Dept. (909) 899-2451 ext. 3086