REQUEST TO CHANGE BENEFIT PLAN

COMPLETE THIS FORM ONLY IF YOU HAVE NO ACCESS TO A DISTRICT COMPUTER OR DISTRICT EMAIL. USE THIS FORM TO CHANGE PLANS OR TO DELETE/ADD DEPENDENT(S). PLEASE DO NOT COMPLETE THIS FORM IF YOU WISH TO RETAIN THE KAISER PLAN OR PPO NETWORK ONLY PLAN. **ALL PPO+ PARTICIPANTS MUST COMPLETE THIS FORM. PLEASE RETURN THE FORM TO THE DISTRICT BY APRIL 30, 2007.**

The effective date of medical coverage for all changes made during this Open Enrollment will be July 1, 2007.

Please make your selection for the Plan Year 2007/2008 (July 2007 – June 2008)

Circle the benefit option to change your current benefit coverage:

	FROM	**TO**
Option 1:	Kaiser Foundation Health Plan (HMO)	PPO + Medical Plan
Option 2:	Kaiser Foundation Health Plan (HMO)	PPO Network Only Medical Plan (PPO)
Option 3:	PPO + Medical Plan	Kaiser Foundation Health Plan (HMO)
Option 4:	PPO + Medical Plan	PPO Network Only Medical Plan (PPO)
Option 5:	PPO Network Only Medical Plan (PPO)	PPO+ Medical Plan
Option 6:	PPO Network Only Medical Plan (PPO)	Kaiser Foundation Medical Plan (PPO)

I wish to keep my current coverage, and insure only the following dependent(s) - (please list all insured eligible dependent(s):

Option A: Maintain Kaiser Foundation Health Plan (HMO)
Option B: Maintain PPO+ Medical Plan
Option C: Maintain PPO Network Only Medical Plan (PPO)

EMPLOYEE NAME: _____ SSN _____ DOB: _____

SPOUSE NAME: _____ SSN _____ DOB: _____

OTHER DEPENDENTS: _____ SSN _____ DOB: _____

_____ SSN _____ DOB: _____

_____ SSN _____ DOB: _____

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP _____

_____ _____
Employee Signature Date

NOTE: Employees with one or more dependents who select the PPO+ Medical Plan will have payroll deductions for monthly premiums effective July 1, 2007. Please return this form to Christine Vo, HR Dept. by the Deadline of Monday, April 30, 2007 or fax it to 650-949-2831.