



MEMBERSHIP ENROLLMENT FORM COMAL INDEPENDENT SCHOOL DISTRICT

Effective Date of Coverage:	
Employee Name:	
Employee Date of Birth:	
Employee Social Security Number:	

Dependent information:	<u>Name</u>	<u>DOB</u>	<u>Relationship</u>

I Elect the Following Coverage:

- Employee Only Coverage: \$7.24
- Employee + One: \$13.94
- Employee & Child(ren): \$14.66
- Employee & Family: \$22.50

Signature :

Date:

