MEMBERSHIP ENROLLMENT FORM
COMAL INDEPENDENT SCHOOL DISTRICT

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

Dependent information:	Name	DOB	Relationship

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: