ENROLLMENT/CHANGE/WAIVER FORM FOR DENTAL AND/OR VISION COVERAGE

EMPLOYER USE ONLY

DENTAL GROUP NUMBER ____________ ____________ ____________ ____________ EFFECTIVE DATE ____________

VISION GROUP NUMBER ____________ ____________ ____________ ____________ EFFECTIVE DATE ____________

COMPLETE THIS SECTION IF YOU ARE ACCEPTING, CHANGING OR TERMINATING COVERAGE

EMPLOYEE'S LAST NAME	FIRST	M.I.	SSN OR EMPLOYER-ASSIGNED ID	DATE OF BIRTH MO / DAY / YR	SEX ☐ F ☐ M

HOME ADDRESS - STREET	CITY	STATE	ZIP

EMPLOYER NAME AND LOCATION (CITY & STATE)	DATE OF HIRE MO / DAY / YR

PLAN(S) YOU WISH TO ENROLL IN (NOTE: YOU MAY ENROLL DEPENDENTS ONLY IN PLANS THAT YOU ENROLL IN)

☐ DENTAL ☐ VISION

LIST ALL ELIGIBLE FAMILY MEMBERS TO BE COVERED

	LAST NAME (IF DIFFERENT)	FIRST	M.I.	RELATIONSHIP SON	RELATIONSHIP DAU.	DATE OF BIRTH MO	DAY	YR
☐ DENTAL ☐ VISION	SPOUSE							
☐ DENTAL ☐ VISION								
☐ DENTAL ☐ VISION								
☐ DENTAL ☐ VISION								
☐ DENTAL ☐ VISION								
☐ DENTAL ☐ VISION								

REASON FOR SUBMITTING THIS FORM

☐ NEW ENROLLEE ☐ REHIRE (Date: ____________)

IF THIS IS FOR CHANGE, WHAT IS THE REASON? — DATE OCCURRED

- ☐ BIRTH/ADOPTION (Name: ____________) ________
- ☐ MARRIAGE/ ☐ DIVORCE ________
- ☐ ADD/ ☐ DROP DEPENDENT (Name: ____________) ________
- ☐ TERMINATION OF BENEFITS (Reason: ____________) ________
- ☐ LOSS OF DENTAL BENEFITS ________
- ☐ NAME CHANGE (Former Name: ____________) ________
- ☐ ADDRESS CHANGE ____________ ________
- ☐ GROUP TRANSFER (From ________ to ________) ________
- ☐ COBRA APPLICATION ________

WHAT TYPE OF DENTAL COVERAGE ARE YOU APPLYING FOR?

☐ EMPLOYEE ONLY ☐ EMPLOYEE & SPOUSE ☐ EMPLOYEE & ONE CHILD
☐ EMPLOYEE & CHILDREN ☐ ENTIRE FAMILY ☐ NONE (See Below)

WHAT TYPE OF VISION COVERAGE ARE YOU APPLYING FOR?

☐ EMPLOYEE ONLY ☐ EMPLOYEE & SPOUSE ☐ EMPLOYEE & ONE CHILD
☐ EMPLOYEE & CHILDREN ☐ ENTIRE FAMILY ☐ NONE (See Below)

YOUR MARITAL STATUS ☐ SINGLE ☐ MARRIED

IF YOU ARE NOT ACCEPTING DENTAL COVERAGE FOR YOUR SPOUSE OR DEPENDENTS, ARE THEY COVERED BY ANOTHER DENTAL PLAN? ☐ YES ☐ NO

IF YOU ARE NOT ACCEPTING VISION COVERAGE FOR YOUR SPOUSE OR DEPENDENTS, ARE THEY COVERED BY ANOTHER VISION PLAN? ☐ YES ☐ NO

☐ **Accept Coverage**

X ______________________________ ____________
SIGNATURE IS REQUIRED DATE

COMPLETE THIS SECTION **ONLY** IF YOU ARE **WAIVING** COVERAGE

EMPLOYEE'S LAST NAME	FIRST	M.I.

SOCIAL SECURITY NUMBER

EMPLOYER NAME AND LOCATION

☐ **Waive Dental**

PLEASE CHECK ONE:

☐ I HAVE DENTAL COVERAGE THROUGH MY SPOUSE
☐ I HAVE OTHER DENTAL COVERAGE
☐ I DO NOT HAVE OTHER DENTAL COVERAGE

☐ **Waive Vision**

PLEASE CHECK ONE:

☐ I HAVE VISION COVERAGE THROUGH MY SPOUSE
☐ I HAVE OTHER VISION COVERAGE
☐ I DO NOT HAVE OTHER VISION COVERAGE

X ______________________________ ____________
SIGNATURE IS REQUIRED DATE