DENTAL PLAN ENROLLMENT/CHANGE FORM

Please print or type - **Note: Changes are not effective until this form is received by Administrator.**

Employee Name _____ _____ _____ _____
Last, First, MI Birth Date Hire Date SS or EE #

I would like to make the following change to my dental plan coverage:

☐ I have changed my Address/Phone _____ _____
Street City/zip

_____
Phone

☐ I have changed my Marital Status as of _____ ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

☐ My spouse has changed employers and no longer has other dental coverage.

☐ My spouse has changed employers and now has other dental coverage through _____

Name of Employer _____

Address/Phone _____ _____ _____
Street City/zip Phone

☐ I am adding a new dependent(s) as of _____ due to ☐ Marriage ☐ Birth ☐ Adoption ☐ Other

If other please explain _____

Name(s) and birth date(s) of new dependents _____

_____

☐ I am deleting the following dependent(s) effective _____ due to ☐ Divorce ☐ Other Coverage ☐ Other

If Other please explain _____

Name(s) of dependent(s) _____

_____

☐ My unmarried dependent child(ren) between age 19 and 23 is/are no longer full time student(s)

Name(s) of dependent(s) _____

☐ I am requesting other changes (please explain) _____

_____

For : name(s) of dependent(s) _____

_____

_____

I hereby request these changes in coverage under my employer's dental plan. I represent that the answers I have given are full, complete and true.

Employee _____ Date _____