

DENTAL AND VISION ENROLLMENT AND CHANGE FORM

Complete the following and submit it to your Human Resources Officer by the open enrollment deadline to make changes or enroll for the first time. You do not need to complete a form to maintain current coverage.

| MEMBER | | | | |
|----------------|------------|------|-------------------------|---------------|
| Last Name | First Name | MI | SSN | County |
| Street Address | | City | | State |
| Worksite | | | Office Telephone Number | Date of Birth |

| DENTAL | | |
|--|--------------------------|--------------------------|
| | Single | Family |
| <input type="checkbox"/> Delta Dental | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Waive Dental coverage | | |

| VISION | | |
|--|--------------------------|--------------------------|
| | Single | Family |
| <input type="checkbox"/> VSP | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> EyeMed | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Waive Vision coverage | | |

| DEPENDENTS | | | | | | | | | |
|--|---|-----|-----------|-----|----------|--------|---|-----------|---|
| <i>Updating dependent information? List your spouse first, then your eligible dependent children. Attach a separate sheet if necessary. For relationship, use SP for Spouse, C for Child, S for Stepchild, G for Legal Guardian or F for Foster Child.</i> | | | | | | | | | |
| First Name | Last Name <small>(if different from yours)</small> | SSN | Birthdate | Sex | Relation | Add to | | Drop from | |
| | | | | | | D | V | D | V |
| | | | | | | D | V | D | V |
| | | | | | | D | V | D | V |
| | | | | | | D | V | D | V |
| <small>ALL DEPENDENTS REQUIRE DOCUMENTATION OF ELIGIBILITY You may use the documentation submitted to establish eligibility for health care for dental and vision coverage.</small> | | | | | | | | | |

I certify the above information to be accurate and that my dependents and I are eligible for benefits. I verify that all dependents meet the Trust's eligibility criteria.

Member Signature _____ Date _____

Payroll/Personnel officers: Please complete the information immediately below, and verify the information above before enrolling employee or making changes.

| | | | |
|------------------------------|-----|--------|-----------------------|
| Employee Appointment Date | CBU | Agency | Effective Date |
| Signature of Agency Designee | | Date | Designee Phone Number |

You are responsible for verifying eligible dependents and providing the effective date.

