# Dental Plan Change Form

Lubbock ISD
Every Child Every Day

Effective date_____

**Reason for Change:** (Please check appropriate category)

- ☐ Newly Married (Date of Marriage) _____
- ☐ Divorced
- ☐ Newborn
- ☐ Spouse Employment Change (Date) _____
- ☐ Dependent Ineligible
- ☐ Add Dependent *****
- ☐ Cancel Dependent
- ☐ Other (please specify)_____

***Dependent children may be covered to 26th birthday.**

**Please Print:**
**Name of Employee: _____ ID# _____**

**Home Address:_____City:_____ State: _____ Zip:_____**

**Sex: Male ☐ Female ☐** **Date of Birth:_____**

**Building or Organization:_____ Position:_____**

***Type Coverage*** **(Check one)** ☐ **Employee Only ($0)** ☐ **Employee & One Dependent ($20.00 Monthly)** ☐ **Employee & Family Coverage ($40.00 Monthly)**

| | NAME | Socials | Date of Birth | Please Check Action Desired |
|---|---|---|---|---|
| Husband ☐ Wife ☐ | _____ | _____ | _____ | Add ☐ Drop ☐ |
| Son ☐ Daughter ☐ | _____ | _____ | _____ | Add ☐ Drop ☐ |
| Son ☐ Daughter ☐ | _____ | _____ | _____ | Add ☐ Drop ☐ |
| Son ☐ Daughter ☐ | _____ | _____ | _____ | Add ☐ Drop ☐ |
| Son ☐ Daughter ☐ | _____ | _____ | _____ | Add ☐ Drop ☐ |

Newborn children are covered from date of birth if added within 30 days of birth.
Spouses are covered from date of marriage if added within 30 days of marriage.
***A 90-day waiting period will apply to any dependents added after initial enrollment*.**
Employees may delete or add dependent coverage to the plan during the month of November only (except for new employees).
Claims must be submitted to the **Risk Mgmt office** within **90 days of payment** of the dental expense. Claims received after that date will be rejected.

*Signature*: _____ **Date:** _____

**I authorize the appropriate monthly payroll deduction for dependent coverage.**

Revised November 2020