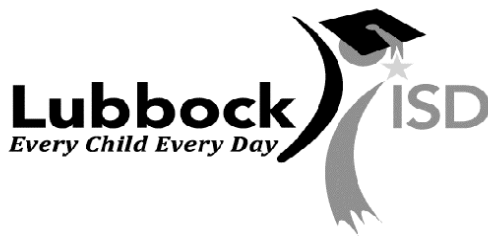


Dental Plan Change Form



Effective date _____

Reason for Change: (Please check appropriate category)

- | | |
|---|---|
| <input type="checkbox"/> Newly Married (Date of Marriage) _____ | <input type="checkbox"/> Dependent Ineligible |
| <input type="checkbox"/> Divorced | <input type="checkbox"/> Add Dependent * |
| <input type="checkbox"/> Newborn | <input type="checkbox"/> Cancel Dependent |
| <input type="checkbox"/> Spouse Employment Change (Date) _____ | <input type="checkbox"/> 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)	<input type="checkbox"/> Employee Only (\$0)	<input type="checkbox"/> Employee & One Dependent (\$20.00 Monthly)
	<input type="checkbox"/> Employee & Family Coverage (\$40.00 Monthly)	

	NAME	Socials	Date of Birth	Please Check Action Desired
Husband	<input type="checkbox"/> _____	_____	_____	Add <input type="checkbox"/> Drop <input type="checkbox"/>
Wife	<input type="checkbox"/> _____	_____	_____	Add <input type="checkbox"/> Drop <input type="checkbox"/>
Son	<input type="checkbox"/> _____	_____	_____	Add <input type="checkbox"/> Drop <input type="checkbox"/>
Daughter	<input type="checkbox"/> _____	_____	_____	Add <input type="checkbox"/> Drop <input type="checkbox"/>
Son	<input type="checkbox"/> _____	_____	_____	Add <input type="checkbox"/> Drop <input type="checkbox"/>
Daughter	<input type="checkbox"/> _____	_____	_____	Add <input type="checkbox"/> Drop <input type="checkbox"/>
Son	<input type="checkbox"/> _____	_____	_____	Add <input type="checkbox"/> Drop <input type="checkbox"/>
Daughter	<input type="checkbox"/> _____	_____	_____	Add <input type="checkbox"/> Drop <input type="checkbox"/>

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.