Dental Plan Administered by

ENROLLMENT FORM FOR GROUP DENTAL INSURANCE BENEFITS
SECTION TO BE COMPLETED BY EMPLOYEE

Name (print) First Middle Last	Social Security No. — —	Date of Birth (Mo./Day/Yr.) / /	☐ Male ☐ Female
Address: Street City State	Zip Code	Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced	
E-mail Address		Phone No. (include area Code) ( )	

DENTAL COVERAGE REQUEST DATA:
I have received and read a copy of my employer's current announcement of the group plan.
I request the following dental coverage:

☐ EMPLOYEE ONLY

☐ EMPLOYEE AND FAMILY

DEPENDENT INFORMATION (COMPLETE ONLY IF YOU CHOOSE EMPLOYEE AND FAMILY COVERAGE ABOVE):
Name(s) of eligible dependents for who coverage is requested (If additional space is needed, attach a separate sheet of paper, signed and dated)

		Date of Birth (Mo./Day/Yr.)	Social Security Number
Spouse:			– –
Child(ren):			– –
			– –
			– –
			– –
			– –

Signature: The employee must sign in all cases. The Proposed Insured signing below declares that all the information given in this enrollment form is true and complete to the best of his/her knowledge and belief. I declare that I am actively at work on the date of this enrollment form. I authorize my employer to deduct the required contributions from my pay for the coverage requested in this enrollment form. This authorization applies to such coverage until I rescind in writing.

Employee Signature _____ Date (Mo./Day/Yr.) _____

SECTION TO BE COMPLETED BY EMPLOYER

Name of Employer (Please Print)		Group Report No.	Sub Division	Branch
Guilford County Schools		350599		
Employer's Street Address	City	State	Zip Code	
712 N. Eugene Street	Greensboro	NC	27401	
Date of Hire (Mo./Day/Yr.)	Coverage Effective Date (Mo./Day/Yr.):			
/ /	/ /			