GUILFORD COUNTY SCHOOLS

Group Dental Reimbursement Plan

Employee Position _____

Enrollment Form

Employee Location _____

PLEASE TYPE OR PRINT

Social Security Number: _____ / _____ / _____

Employee Name: _____
First Middle Initial Last

Address: _____
Street City State Zip

Employee's Birthdate: _____ / _____ / _____ Employee Sex _____

Name of Spouse _____ Spouse's Birthdate: _____ / _____ / _____ Spouse's Sex: _____

Do you have any eligible dependent children? YES _____ NO _____ If Yes, Number _____

Is anyone covered by another Dental Plan?
Employee: YES _____ NO _____
Spouse: YES _____ NO _____
Children: YES _____ NO _____

If Yes, please indicate the Name and Address of the Other Dental Plan _____
_____
_____

The Guilford County Schools Group Dental Plan will reimburse covered employees and their covered dependents for eligible dental expenses incurred during a Plan Year. A Plan Year is the twelve-month period beginning January 1st and ending December 31st. No deductible is required. See Plan Booklet for details.

PLEASE NOTE: Any employee, who has eligible dependents at the time the employee first becomes eligible for dental coverage and desires dependent coverage, must enroll for dependent coverage at that time and agree to maintain dependent coverage until the next Plan Anniversary of January 1st subject to plan provisions. Any employee who has eligible dependents, but does not elect dependent coverage when initially offered, will be subject to a one-year waiting period on all eligible expenses incurred by any covered dependent, except preventive care.

SPECIAL NOTE: An eligible employee who is covered by another dental plan may decline coverage under this plan. Thereafter coverage under this Plan may only be applied for on the Plan Anniversary of January 1st. Coverage will be subject to a one-year waiting period on all eligible expenses incurred, except preventive care.

FOR EMPLOYEE ONLY COVERAGE: I hereby request coverage for myself only and authorize the necessary payroll deduction, if any is required. I understand the dependent coverage requirements as stated above.

Employee's Signature: _____ Date Signed: _____

FOR EMPLOYEE AND DEPENDENT COVERAGE: I hereby request coverage for myself and my eligible dependents and authorize the necessary payroll deduction, if any is required. I understand the dependent coverage requirements as stated above.

Employee's Signature: _____ Date Signed: _____

TO DECLINE COVERAGE: I hereby decline all coverage under this Plan. I understand the waiting period and enrollment requirements as stated above.

Employee's Signature: _____ Date Signed: _____

(**For Benefits Dept. Use Only** – Employee's Effective Date of Coverage _____ / _____ / __

WHITE – PLAN SUPERVISOR YELLOW – EMPLOYEE