

Employee Name: First \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last \_\_\_\_\_

Address: \_\_\_\_\_

Employee's Social Security Number: XXX / XX / \_\_\_\_\_

**I REQUEST THE FOLLOWING CHANGES:**

( ) **Change Name To:** First \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last \_\_\_\_\_

Change Because:  Marriage  Legal Change

( ) **Change My Coverage To:**  Employee Only  Family  Decline

( ) **Add, Change or Remove Dependents:**  Remove  Spouse  
 Change  Dependent Child (or Children)  
 Add

( ) **Reason and Date of Event Required:**

- Marriage ( \_\_\_ / \_\_\_ / \_\_\_ )  Student ( \_\_\_ / \_\_\_ / \_\_\_ )  Transfer From Spouse ( \_\_\_ / \_\_\_ / \_\_\_ )
- Legal Separation ( \_\_\_ / \_\_\_ / \_\_\_ )  Newborn ( \_\_\_ / \_\_\_ / \_\_\_ )  No Longer Student ( \_\_\_ / \_\_\_ / \_\_\_ )
- Divorce ( \_\_\_ / \_\_\_ / \_\_\_ )  Step/Adopted/  
or Foster Child ( \_\_\_ / \_\_\_ / \_\_\_ )  Max Student Age 26 ( \_\_\_ / \_\_\_ / \_\_\_ )
- Death ( \_\_\_ / \_\_\_ / \_\_\_ )  Other ( \_\_\_ / \_\_\_ / \_\_\_ ) \_\_\_\_\_  Max Child Age 19 ( \_\_\_ / \_\_\_ / \_\_\_ )

( ) **DEPENDENT INFORMATION:** List dependents to be included. Specify last name if different. Complete \**Certification of Dependent Eligibility Form* for foster or adopted children. List additional children on separate form.

**Spouse:** First \_\_\_\_\_ Initial \_\_\_\_\_ Last \_\_\_\_\_ Birthdate ( \_\_\_ / \_\_\_ / \_\_\_ ) Sex  Male  Female

Remove  Add

Address (if different): \_\_\_\_\_

**Child:** First \_\_\_\_\_ Initial \_\_\_\_\_ Last \_\_\_\_\_ Birthdate ( \_\_\_ / \_\_\_ / \_\_\_ ) Sex  Male  Female

Remove  Add

Address (if different): \_\_\_\_\_

**Child:** First \_\_\_\_\_ Initial \_\_\_\_\_ Last \_\_\_\_\_ Birthdate ( \_\_\_ / \_\_\_ / \_\_\_ ) Sex  Male  Female

Remove  Add

Address (if different): \_\_\_\_\_

**Child:** First \_\_\_\_\_ Initial \_\_\_\_\_ Last \_\_\_\_\_ Birthdate ( \_\_\_ / \_\_\_ / \_\_\_ ) Sex  Male  Female

Remove  Add

Address (if different): \_\_\_\_\_

\* **If Student** – list dependent's name and university, college or accredited vocational school below:

Dependent Name: \_\_\_\_\_ School/College/University: \_\_\_\_\_

( ) **OTHER GROUP DENTAL COVERAGE:**  No  Yes (Please complete if you or your dependents have other group dental coverage.)

Name/Address of other insurance company providing coverage: \_\_\_\_\_

**Employee Authorization:**

I hereby apply for the changes, adjustments and/or additions to my plan enrollment listed on the form above and I agree that all information provided is correct. I further agree that we shall abide by the provisions of the agreement for the plan in which we are enrolled. I authorize my employer to deduct from my earnings any deduction for the coverage elected above.

Employee's Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

Effective Date: \_\_\_\_\_ White – Plan Supervisor Yellow – Employee