



DENTAL AND VISION ENROLLMENT/CHANGE FORM

FOR OFFICE USE ONLY (All fields are REQUIRED)

Effective Date of Change: _____
 HR/Payroll Rep: _____
 Pay Type: _____
 Campus: _____
 Date Event Occurred: _____

Check the box for the benefit(s) you would like to enroll in or make changes to. All Employee and applicable Dependent sections must be completely filled out in the event you are making changes. Descriptions of each Plan can be found on your HR's website or in the Benefits Book. Contact your local HR/Benefit Staff for additional information.

TYPE OF CHANGE (REQUIRED)

Birth/Adoption	New Hire	Death
Marriage	Emp Status	Divorce
Retirement	Termination	Add/Delete Dependent
Cancellation	Demographic	Change Other

Last Name		First Name		MI	Social Security #	
Mailing Address				City	State	Zip Code
Gender	Home Phone	Work Phone		Email Address		
Birth date		Hire date		Marital date		Retirement date

<input type="checkbox"/> Add <input type="checkbox"/> Delete	SPOUSE	Last Name	First Name	MI	SSN	Gender	DOB
<input type="checkbox"/> Add <input type="checkbox"/> Delete	DEPENDENT	Last Name	First Name	MI	SSN	Gender	DOB
<input type="checkbox"/> Add <input type="checkbox"/> Delete	DEPENDENT	Last Name	First Name	MI	SSN	Gender	DOB
<input type="checkbox"/> Add <input type="checkbox"/> Delete	DEPENDENT	Last Name	First Name	MI	SSN	Gender	DOB
<input type="checkbox"/> Add <input type="checkbox"/> Delete	DEPENDENT	Last Name	First Name	MI	SSN	Gender	DOB
<input type="checkbox"/> Add <input type="checkbox"/> Delete	DEPENDENT	Last Name	First Name	MI	SSN	Gender	DOB

DENTAL	Level of Coverage	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
	Basic Plan	<input type="checkbox"/> \$17.88	<input type="checkbox"/> \$33.60	<input type="checkbox"/> \$46.45	<input type="checkbox"/> \$62.16
	Enhanced Plan	<input type="checkbox"/> \$32.87	<input type="checkbox"/> \$64.33	<input type="checkbox"/> \$78.19	<input type="checkbox"/> \$109.62
	<input type="checkbox"/> I am enrolling in dental coverage <input type="checkbox"/> I am cancelling dental coverage <input type="checkbox"/> I do not wish to enroll				

VISION	Level of Coverage	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
	Premium	<input type="checkbox"/> \$7.39	<input type="checkbox"/> \$12.45	<input type="checkbox"/> \$12.72	<input type="checkbox"/> \$20.50
	<input type="checkbox"/> I am enrolling in vision coverage <input type="checkbox"/> I am cancelling vision coverage <input type="checkbox"/> I do not wish to enroll				

To enroll, cancel, or make changes to Life, Critical Illness, Accident, Long Term Disability, or AD&D, please fill out the Financial Protection Enrollment Form.

To enroll, cancel, or make changes to your Health Insurance or Flexible Spending Account(s), please contact your HR department.

I authorize my employer to deduct from my wages the premiums, if any, for the elected coverage. To the best of my knowledge and belief, the information I have provided on this form is correct. I understand that any persons who knowingly present a false or fraudulent claim for payment of loss or benefit or knowingly present false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Employee Signature: _____ Date: _____