Benefits Enrollment Form - Vision & Dental 2024-2025

Effective Date of Enrollment Change: January 1, 2025

EMPLOYEE/PARTICIPANT INFORMATION

Please **PRINT** and fill this section out **COMPLETELY**

Social Security #:	Last Name:	First Name:	M.I.:
Gender:	Date of Birth:	Address:	

City:	State:	Zip:	Home Phone #:	Work Phone #:

Marital Status:

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widow

PLEASE NOTE THIS FORM IS TO BE COMPLETED FOR ENROLLING IN DENTAL AND VISION COVERAGE. IF YOU ARE WAIVING COVERAGE, PLEASE CHECK THE APPROPRIATE BOX NEXT TO EACH BENEFIT ON THIS FORM.

DEPENDENT INFORMATION (Spouse, Child or Children) / Please **PRINT** and fill this section out **COMPLETELY** / **Please list all eligible dependents**

Spouse

Social Security #:	First Name:	Last Name:	M.I.:
Date of Birth	Gender:		

Child(ren)

Social Security #:	First Name:	Last Name:	MI:
Date of Birth:	Gender:		
Relationship:			

Social Security #:	First Name:	Last Name:	MI:
Date of Birth:	Gender:		
Relationship:			

Social Security #:	First Name:	Last Name:	MI:
Date of Birth:	Gender:		
Relationship:			

Social Security #:	First Name:	Last Name:	MI:
Date of Birth:	Gender:		
Relationship:			

Delta Dental

Type of Coverage:	
☐ Single ☐ Married ☐ Parent/Child(ren) ☐ Family	☐ I do NOT wish to enroll in dental coverage ☐ I wish to CANCEL my dental coverage

National Vision Administrators (NVA) Vision Plan

Type of Coverage:	
☐ Single ☐ Married ☐ Parent/Child(ren) ☐ Family	☐ I do NOT wish to enroll in vision coverage ☐ I wish to CANCEL my vision coverage

EMPLOYEE CERTIFICATION

I certify that all of the information supplied on this form is true to the best of my knowledge. I understand if I waive my right to coverage at this time, enrollment is not permissible until the next scheduled open enrollment. I understand that there is no guarantee of continuous participation by medical service providers, doctors or facilities in the Plans. If either my physician or medical center terminates participation in the Plan, I must select another doctor or medical center participating in the same plan. I authorize any hospital, physician or health care provider to furnish my medical plan or its assignee with such medical information about myself or my covered dependents as the medical plans or assignee may require. I also attest that the dependents listed here (if applicable) meet the dependent eligibility criteria of the Plan. I understand that in the event I cover any dependent that does not meet the eligibility provisions of the Plan that doing so shall invalidate their coverage and potentially my coverage and that I may be subject to penalties. I further agree that the district may, at any time, request that I supply evidence that substantiates the eligibility status of any person I cover as a dependent under the Plan.

Print Name: ____ Employee Signature: ____

Date:____________