2019-2020 Dental Enrollment Form

EMPLOYEE INFORMATION:			
Name:	**LAST** **FIRST** **MI**	**Social Security Number:**	
Home Address:	**STREET**	**Date of Birth** (MM/DD/YYYY)	
	CITY **STATE** **ZIP**	**Home Phone**	
Marital Status	□ Single □ Married □ Divorced □ Separated □ Domestic Partner	**Gender**	
		Email	
Job Title:		**Date of Hire** (MM/DD/YYYY)	
Enrollment Type:	□ New		
Effective Date: July 1, 2018			

INSURED INFORMATION (Complete entire line for all listed)

	Last Name	First Name	MI	Date of Birth	Gender	Social Security No.
Employee						
Spouse						
Child						
Child						
Child						
Child						

NOTE: ALL DEDUCTIONS ARE PROCESSED BI-WEEKLY (26 pay periods per year)

Dental Options – CareFirst
2018 -2019 Group Dental Election

SELECT ONE DENTAL OPTION:	**Blue Dental Plus Plan**
Waive/Decline Coverage	□ $0.00
Employee Only	□ $5.19
Employee/Child	□ $9.60
Employee/Spouse	□ $11.93
Family	□ $15.77

Employee Signature Authorization:

To the best of my knowledge and belief, the information required on this form is correct. I understand that false or inaccurate information may result in the termination of coverage or the nonpayment of benefits. I understand that by signing and submitting this form to elect coverage, I am making a binding election for my benefits and am authorizing deductions from my earnings until the next annual enrollment period. I understand that if I am waiving any coverage at this time, I may be subject to limitation or exclusion from coverage at a later date. If I have marked that I am declining coverage, my signature below affirms that waiver. If for any reason I fail to complete a new enrollment form each plan year, the elections shown on this form will remain unchanged, although the cost may change.

Signature: ***Date:***

Return completed/signed form to Human Resources