



Dental Plan Enrollment / Change Form

Open Enrollment 2027 plan year

Name _____ Employee ID# _____

Address _____

City _____ State _____ Zip _____

Date of Birth _____ Phone number _____

____ Monthly ____ Biweekly ____ Retiree ____ **COBRA**

OFFICE USE ONLY:

Approval _____

Effective Date 01/01/2027

1. ☐ **New Enrollment** ☐ **Add / Drop Dependent (circle one)** ☐ **Decline / Cancel Plan (circle one)**
Complete Sections 2, 3, 4, 5, & 6 Complete Sections 2, 3, 4, 5, & 6 Complete Sections 2 & 7

2. **Qualifying event:** Please circle one and print date of the event. All NEISD forms must be received in the Employee Benefits office within 31 days from, and including, your qualifying event date.

____/____/____ New Employee ____/____/____ Birth* or Adoption* (circle one) ____/____/____ Marriage* or Divorce* (circle one)
____/____/____ Loss or gain of dental coverage* (circle one) ____/____/____ Other* _____

**Supporting Documentation will be required before processing.*

3. **Select your plan:** ☐ **Low Option** ☐ **High Option**

4. **Select your coverage level:** ☐ **Emp. Only** ☐ **Emp./Child(ren)** ☐ **Emp./Spouse** ☐ **Emp./Family**

5. **Dependent Information:** Employees are required to supply *supporting documentation* and/or *additional forms* for stepchildren and/or other dependents with different last names.

	Relationship	Dependent Name	Sex	Date of Birth	Social Security # {Required}
____ Add ____ Drop	Spouse				
____ Add ____ Drop	Child				
____ Add ____ Drop	Child				
____ Add ____ Drop	Child				

6. **Acceptance/Certification:**

I hereby request to be a participant under the NEISD Dental Plan. I understand that no benefit will become effective until the latest of the effective date of the plan or the date on which I satisfy the minimum service requirement as stated in the plan document. I hereby authorize my employer to make necessary payroll deductions from my paycheck, if any are required. I reserve the right to revoke the payroll deduction authorization during the annual NEISD open enrollment period.

I hereby certify that the above information is correct. I also understand that I must notify Employee Benefits within 31 calendar days if any dependent ceases to be eligible.

Employee Signature

Date

Campus/Department

7. **Declination or Cancellation of Benefit:**

After careful consideration, I have decided NOT to participate in or cancel the dental plan benefit and waive my rights to such benefit.

Employee Signature

Date

Campus/Department

Revised 02/18