Dental Plan Enrollment / Change Form

OFFICE USE ONLY:	
Approval	_____
Effective Date	_____

_____
Name Employee ID#

_____
Address

_____
City State Zip

_____ ____ Monthly ____ Biweekly ____ Retiree ____ COBRA
Date of Birth Phone number

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