Enroll in (check all that apply): ____ Dental ____ Vision

Change Type: ☐ Add ☐ Term ☐ Update

Employee Information (as appears on payroll)

______________________ ______ ______________________
First Name **M.I.** **Last Name**

____
Street Address

______________ ______ ______ ______________
City **State** **Zip** **Phone Number**

_____-____-_____ ____/____/____ M / F ______________
Social Security # **Date of Birth** **Gender (Circle One)** **Email Address**

Spouse Information

Enroll in (check all that apply): _____ Dental _____ Vision

______________________ ______ ______________________
First Name **M.I.** **Last Name**

____/____/____ _____-____-_____ M / F
Date of Birth **Social Security #** **Gender (Circle One)**

Dependent Information

Enroll in (check all that apply): _____ Dental _____ Vision

______________________ ______ ______________________
First Name **M.I.** **Last Name**

____/____/____ _____-____-_____ M / F
Date of Birth **Social Security #** **Gender (Circle One)**

______________________ ______ ______________________
First Name **M.I.** **Last Name**

____/____/____ _____-____-_____ M / F
Date of Birth **Social Security #** **Gender (Circle One)**

**Use additional sheets to add more dependents

I authorize any payroll deduction that may be required towards the cost of this coverage. I certify that the information in this form is true and correct to the best of my ability. I understand that my election cannot be changed during the year unless I experience a change in family status and the election change is consistent with the family status change.

Signature of Enrollee ______________________________ Date:______________________