NORTH ROSE-WOLCOTT CENTRAL SCHOOL DISTRICT

Dental Plan Enrollment/Change Form

Date: _____

Subject:
New Employee Dental Enrollment ☐
Employee Dental Change ☐
Cancel Dental Coverage ☐
Name/Address Change ☐

Type of Coverage:
Single ☐
Family ☐

Name: _____ **Gender:** Male ☐ Female ☐

Address: _____ **SSN:** _____

_____ **Birthdate:** _____

Telephone: **( )** _____

Dependents:

	Name	*	Sex	Birthdate	Social Security No.
Spouse					
Child					
Child					
Child					
Child					

*Indicate **F** if full-time student age 19 or over or indicate **H** if handicapped

Is spouse employed? Yes ☐ No ☐ If yes, employer's name: _____

Is anyone listed above covered by another dental plan? Yes ☐ No ☐

Policy Holder: _____ Persons Covered: _____

Plan: _____ ID Number: _____

Employee Signature: _____ **Date:** _____

Effective: _____/_____/_____ Facility: _____ Unit: Teachers

Employer Signature: _____ Date: _____

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