Delta Dental, Davis Vision & Sheriff's Disb
Employee Enrollment/Change Form

EMPLOYEE

SOCIAL SECURITY NO.	INSTRUCTIONS: NEW EMPLOYEE-Complete all unshaded areas and sign the form. CHANGES-Enter new or corrected information in the unshaded areas. Be sure to include your Social Security No. It is not necessary to complete the entire form.	ADD	CHANGE	CLIENT NO.	COMPANY	LOCATION	UNIT

LAST NAME	FIRST NAME	M.I.	MAILING ADDRESS	CITY	STATE	ZIP CODE

BIRTH DATE	SEX	MARITAL STATUS M-Married S-Single D-Divorced W-Widow L-Legally Separated ▶		MARRIAGE DATE	EMPLOYMENT DATE

SPOUSE

LAST NAME (If Different)	FIRST NAME	M.I.	BIRTH DATE	SEX	DISABLED?	SPOUSE SOCIAL SECURITY #

IS YOUR SPOUSE EMPLOYED? ▶	Y / N	IF YES, NAME OF EMPLOYER	DOES YOUR SPOUSE HAVE OTHER GROUP DENTAL INSURANCE?	Y / N	IF YES, NAME OF OTHER INSURANCE CARRIER	GROUP NO.

OTHER DEPENDENTS

LAST NAME (If Different)	FIRST NAME	M.I.	BIRTH DATE	SEX	SSN

IF MORE SPACE IS NEEDED TO LIST DEPENDENTS, ATTACH ANOTHER FORM. BE SURE TO ENTER YOUR SOCIAL SECURITY NUMBER.

OFFICE USE ONLY

IN THE SPACE BELOW, PLEASE MAKE YOUR BENEFIT(S) SELECTION. IF YOU HAVE ANY QUESTIONS REGARDING ELIGIBILITY, COVERAGE, AND THE LIKE…CONSULT YOUR EMPLOYER BEFORE MAKING Y OUR SELECTION.

BENEFITS

TYPE	ELECTING COVERAGE Y/N	SINGLE/FAMILY	CODE	EFFECTIVE DATE	CANCELLATION DATE	CODE
Delta Dental						
Davis Vision						
Sheriff's Disability						

ALL INFORMATION PROVIDED HEREON IS TRUE AND COMPLETE TO THE BEST O F MY KNOWLEDGE. I HEREBY AUTHORIZE MY EMPLOYER TO MAKE ANY REQUIRED PAYROLL DEDUCTIONS.

EMPLOYEE SIGNATURE DATE

DATE

EMPLOYER REPRESENTATIVE

***Please note that new hires for Rensselaer County that waive enrollment into a health insurance plan have a one year wait before vision coverage becomes effective.**