



Wyandotte Public Schools DENTAL ENROLLMENT FORM

Eligibility/Change/Termination Report

Union/Division: _____

General Information - Employee

Name (Last)	(First)	(Middle)	Sex	Birth Date	Social Security #
Address (Street)					
City		State		Zip Code	
Occupation	Hire Date	Effective Date	Plan		

Section 2 - Dependent Information

Name (Last)	(First)	(Middle)	Sex	Date of Birth	Relationship	Effective Date

Is there a court order requiring coverage for any dependent in the case of divorced or legally separated parents? Yes No

Section 3 - Change/Correction

A. Name Change

	Last Name	First Name	Social Security #	Effective Date
Employee: From:				
To:				
Dependent: From:				
To:				

B. Termination of Benefits

Employee Effective Date of Termination _____

Dependent Effective Date of Termination: _____

Spouse: _____

Dependent(s): _____

C. Additional Coverage - Will this enrollment result in coverage under more than one dental program for you or your spouse? Yes _____ No _____

Signature _____ Date _____