

**SECTION 1 – EMPLOYEE INFORMATION (Please complete in full and print clearly.)**

Employee Last Name	First	MI	Social Security # - -	
Street Address			Phone Number	
City	State	Zip Code	Date of Birth	Employee #
Contract Group	Hours Per Week	Employee Hire Date		

**SECTION 2 – REASON FOR CHANGE/ENROLLMENT**

- Enrollment
  Declining Coverage  
 Adding Dependents  
 Dropping Dependents
  Other: \_\_\_\_\_

**SECTION 3 – DENTAL PLAN**

- |   |   |                          |
|---|---|--------------------------|
| <input type="checkbox"/> Dental Coverage<br><br><input type="checkbox"/> Decline Dental | <input type="checkbox"/> Single<br><input type="checkbox"/> Single + 1<br><input type="checkbox"/> Family | Effective Date:<br>_____ |
|---|---|--------------------------|

**SECTION 4 – EMPLOYEE AND DEPENDENT INFORMATION**

Add	Drop	Relationship to Employee	First Name, Middle Initial (last name only if different from employee)	Gender	Date of Birth (required)	Social Security #
<input type="checkbox"/>	<input type="checkbox"/>					
<input type="checkbox"/>	<input type="checkbox"/>					
<input type="checkbox"/>	<input type="checkbox"/>					
<input type="checkbox"/>	<input type="checkbox"/>					
<input type="checkbox"/>	<input type="checkbox"/>					

**SECTION 5 – EMPLOYEE SIGNATURE**

I understand that this election cannot be revoked or changed until the next open enrollment period, unless there is a loss of eligible or life event. The change must be made within 30 days from the date of the life event. (Please contact your Human Resources generalist or refer to the benefits booklet for the life event information.)

\_\_\_\_\_  
EMPLOYEE SIGNATURE

\_\_\_\_\_  
DATE SIGNED

My Spouse is also employed with the district

**Authorize Electronic Submission**  
 By checking this box and typing my name, I acknowledge that this constitutes a legal signature confirming that I agree to the these terms as if I physically signed this document.

**For HR Use Only**    EFP: \_\_\_\_\_    Delta Dental: \_\_\_\_\_    HRS: \_\_\_\_\_    Audit: \_\_\_\_\_  
 Deductions:  Full Year     August     September     October