

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: _____