

Application for Dental, Vision, Life & Disability Insurance

Delta Dental of Minnesota
VSP & EyeMed Vision / Standard Life Insurance Co.

EMPLOYER	<input type="checkbox"/> New Enrollment <input type="checkbox"/> Late Enrollment <input type="checkbox"/> Change Address <input type="checkbox"/> Change Name	<i>Make Change to Existing Coverage</i>		<i>Make Change to Existing Coverage</i>	
		<input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Cancel <input type="checkbox"/> Add Dependent(s) <input type="checkbox"/> Remove Dependent(s) <input type="checkbox"/> Other:		<input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Cancel <input type="checkbox"/> Add Dependent(s) <input type="checkbox"/> Remove Dependent(s) <input type="checkbox"/> Other:	
Oakes Public Schools		Date of Change:		Date of Change:	
EMPLOYEE NAME (Last, First, MI)		DATE OF BIRTH		SOCIAL SECURITY #	
MAILING ADDRESS		CITY		STATE	
DATE OF EMPLOYMENT		EMAIL		DAYTIME PHONE	
MARITAL STATUS:		<input type="checkbox"/> Single <input type="checkbox"/> Married		EFFECTIVE DATE:	

DENTAL INSURANCE – Indicate desired coverage
<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Employee & Children <input type="checkbox"/> Employee & Family <input type="checkbox"/> I Decline Dental coverage

VISION INSURANCE – Indicate desired coverage	
<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Employee & Children <input type="checkbox"/> Employee & Family <input type="checkbox"/> I Decline Vision coverage	<input type="checkbox"/> VSP Choice Network <input type="checkbox"/> EyeMed Access Network

DEPENDENT COVERAGE	List eligible family members to be enrolled in dental and/or vision insurance			
NAME	DATE OF BIRTH	SEX	Enroll in Dental?	Enroll in Vision?
<i>Spouse</i>			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>Child 1</i>			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>Child 2</i>			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>Child 3</i>			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>Child 4</i>			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>Child 5</i>			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>Child 6</i>			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

I hereby apply for the insurance coverage indicated above. I authorize my employer to make any necessary deductions from my salary to pay the premium when my insurance becomes effective.

Employee Signature _____ Date _____