GRAND BLANC COMMUNITY SCHOOLS ENROLLMENT/CHANGE FORM

For Dental Coverage **Union/Division:___________________**

General Information - Employee

Name (Last) (First) (Middle) Gender Birth Date Social Security #

Address (Street) City State Zip Code

Occupation Hire Date Effective Date Plan

Section 2 – Dependent Information

Name (Last)	(First)	(MI)	Gender	Date of Birth	Relationship	Effective Date	Social Security #	Enroll	Delete

Is there a court order requiring coverage for any dependent in the case of divorced or legally separated parents?
Yes______No_______If yes, please attach copy of health care coverage page.

B. Additional Coverage - Will this enrollment result in coverage under more than one dental program for you or your spouse?

Dental: Yes ____________ No___________

If Yes: Carrier name: ____ID #:_____________________________

Signature ____Date_________________