

Northern School District Trust

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DENTAL ENROLLMENT

NSDT
c/o CESA #12
400 Lake Shore Dr. E
Ashland, WI 54806

Employee	Last Name _____	First _____	M.I. _____	Date of Birth _____	Social Security # _____
	Address _____				
	City _____ State _____ Zip _____			Home Phone # _____	
	Sex <input type="checkbox"/> M <input type="checkbox"/> F			Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married	
Coverage	_____ Single _____ Family _____ Other _____				
Spouse/ Dependents	SPOUSE: Last Name _____ First _____ M.I. _____				
	Date of Birth _____ Employer _____ SS# _____				
	Dependents:				
	First Name _____	M.I. _____	Last (If Different than Employee) _____	Date of Birth _____	Sex (M or F) _____
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
Other	Are any dependent children over 18? <input type="checkbox"/> Y <input type="checkbox"/> N. If Yes, do they attend school full-time? <input type="checkbox"/> Y <input type="checkbox"/> N				
	If Yes, where? _____				
	Do you provide more than 50% of the economic support of the dependents listed above? <input type="checkbox"/> Y <input type="checkbox"/> N				
Refuse	Did you claim all of the dependents listed above on your last income tax return? <input type="checkbox"/> Y. <input type="checkbox"/> N				
	Do you, your spouse, or any of your dependents have any other Dental coverage? <input type="checkbox"/> Y <input type="checkbox"/> N				
Accept	If Yes, Name of Company _____ Policy # _____				
	I have decided not to apply for the Dental Coverage Offered for: <input type="checkbox"/> Self <input type="checkbox"/> Dependents <input type="checkbox"/> Other and I understand that evidence of insurability may be requested if I desire to apply for such coverage at a later date.				
Refuse	Signature _____				Date _____
	I enroll for the eligible benefits I indicated in the coverage section and authorize deductions from my earnings if required.				
Accept	Signature: _____				Date: _____

Employer Complete: District: _____ Group# _____

Position of Applicant: _____

Effective Date of Coverage: _____ Hire Date: _____