

Indemnity Dental Plan Enrollment Form

Group Name: **Sunnyvale School District**

New Enrollment
Effective date: _____

Employee Details:

Last Name		Contact Phone #	
First Name		Gender	
Middle Initial		SSN	
Address		Date of Birth	
City			
Zip Code			

Dependent Information:

Last Name	First Name	SSN	Relationship	Gender	Birth Date		
						male	female

I certify that the above is correct to the best of my knowledge. I understand that Sunnyvale School District may require proof of dependent eligibility.

Employee Signature _____

Date _____