



Maggie Brooks
County Executive

MONROE COUNTY DENTAL ASSISTANCE PLAN ENROLLMENT/CHANGE FORM

NEW APPLICATION **CHANGE** **CANCELLATION** **COVERAGE:** **SINGLE** **FAMILY**
REASON FOR CHANGE: **MARRIAGE** **BIRTH** **DIVORCE** **DEATH** **OTHER** _____

Employee Name: _____ Sex: _____
Last First MI
 Address: _____ City: _____ State: _____ Zip: _____
 Birth Date: _____ Social Security #: _____
 Telephone #: _____ Date of hire: _____ SAP#: _____

Dependents To Be Covered (Spouse/Children)

	Name	A/C ^Δ	F/H*	Sex	Birth Date Mo/Day/Yr	Social Security #
(Spouse)	_____	_____	_____	_____	_____	_____
(Child)	_____	_____	_____	_____	_____	_____
(Child)	_____	_____	_____	_____	_____	_____
(Child)	_____	_____	_____	_____	_____	_____
(Child)	_____	_____	_____	_____	_____	_____
(Child)	_____	_____	_____	_____	_____	_____

^Δ Mark **A** if adding coverage for a dependent; Mark **C** if canceling coverage for a dependent.
 * Mark **F** if full-time student aged 19 or over; Mark **H** if handicapped dependent.

IT IS THE EMPLOYEE'S RESPONSIBILITY TO KEEP ALL DATA REQUESTED ON THIS APPLICATION CURRENT AND TO REPORT ANY CHANGES IN STATUS TO THE HUMAN RESOURCES DEPARTMENT. FAILURE TO REPORT CHANGES MAY RESULT IN A DELAY IN PAYMENT OF BENEFITS.

OTHER DENTAL COVERAGE

Do you have dental insurance coverage for yourself, your spouse, or your dependent children other than through Monroe County? _____ **YES** _____ **NO**. If you answered **YES**, please complete the information below:

If Spouse is Employed:
 Employer's Name: _____
 Employer's Address: _____
 Name and Address of:
 Spouse's Dental Plan Carrier(s): _____
 Group Number(s): _____
 Person(s) Covered: _____

I herby authorize Monroe County to make payroll deductions in the amount approved for the coverage selected.

Employee's Signature: _____ **Date** _____

To Be Completed By Employer:

Effective Date: _____ Termination Date: _____
 Employer's Signature: _____ Date: _____