Cheryl Dinolfo
County Executive

MONROE COUNTY DENTAL ASSISTANCE PLAN ENROLLMENT/CHANGE FORM

Rev 1/2016

☐ **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 ID: _____

Dependents To Be Covered or Canceled (Spouse/Children)

	Name	A/C[Δ]	F/H*	Sex	Birth Date MM/DD/YYYY	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.

NOTE:

- **COVERAGE ENDS WHEN THE CHILD REACHES AGE 23 OR IS NO LONGER A FULL TIME STUDENT, WHICHEVER OCCURS FIRST**
- **IT IS THE EMPLOYEE'S RESPONSIBILITY TO REPORT ANY CHANGES IN STATUS TO THE HR DEPARTMENT**
- **FAILURE TO REPORT CHANGES MAY RESULT IN CANCELLATION OF BENEFITS**

OTHER DENTAL COVERAGE

Do you have ANY other dental insurance coverage for yourself, your spouse, or your dependent children?
_____ 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: _____

Please return this enrollment/change form to:
Human Resources, Room 210, County Office Building
39 West Main Street
Rochester, NY 14614
e-mail: hrbenefits@monroecounty.gov