Humana Specialty Benefits
Dental Plan Enrollment/Change Form

OFFICE USE ONLY:	
Cafeteria Plan	_____Y _____N
Mainframe	_____
Humana	_____
Approval	_____
Effective Date	_____

_____
Name

_____
Address

_____
City State Zip

_____
Date of Birth Social Security Number ____ Monthly ____ Biweekly ____ Retiree ____ COBRA

1. _____ **New Enrollment** Complete Sections 2, 3, 4, & 5 _____ **Add/Drop Dependent** Complete Sections 2, 3, 4, & 5 _____ **Decline/Cancel Plan** Complete Sections 2 & 6

2. **Reason for Section 1:** Please indicate **date** of event. ***Supporting Documentation will be required***

__/__/__ New Employee __/__/__ Birth*/Adoption* __/__/__ Spouse Begins/Ends Employment*

__/__/__ Marriage*/Divorce* __/__/__ Dependent becomes Ineligible __/__/__ Other* _____

3. **Type of Coverage:**

_____ **Employee Only** $23.00 _____ **Employee/Child(ren)** $57.00 _____ **Employee/Spouse** $61.00 _____ **Employee/Family** $73.00

4. **Dependent Information:** Employees are required to supply *supporting documentation* and/or *additional forms* for stepchildren and/or other dependents with different last names.

	Relationship	Dependent Name	Sex	Date of Birth	Social Security # {Required}
____ Add ____Drop	**Spouse**				
____ Add ____Drop	**Child**				
____ Add ____Drop	**Child**				
____ Add ____Drop	**Child**				

5. **Acceptance/Certification:**
I hereby request to be a participant under the North East I.S.D. Dental Plan. I understand that no benefit will become effective until the latest of the effective date of the plan or the date on which I satisfy the minimum service requirement as stated in the plan document. I hereby authorize my employer to make necessary payroll deductions from my paycheck, if any are required. I reserve the right to revoke the payroll deduction authorization annually on the plan anniversary date.

I hereby certify that the above information is correct. I also understand that I must notify Employee Benefits within 31 calendar days if any dependent ceases to be eligible.

_____ _____ _____
Employee Signature Date Campus/Department

6. **Declination or Cancellation of Benefit:**
After careful consideration, I have decided NOT to participate in or cancel the dental plan benefit and waive my rights to such benefit.

_____ _____ _____
Employee Signature Date Campus/Department

Original: Employee Benefits **Copy:** Employee Revised 7/2011