



North East Independent School District

Dental Plan Enrollment/Change Form

OFFICE USE ONLY:	
Cafeteria Plan	____ Y ____ N
Mainframe	_____
CompBenefits	_____
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
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2. **Reason for Section 1:** Please indicate date of event. **Documentation will be required.*

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

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

3. **Type of Coverage:**

____ **Employee Only** ____ **Employee/Child(ren)** ____ **Employee/Spouse** ____ **Employee/Family**

 \$22.00 \$55.00 \$58.00 \$69.00

4. **Dependent Information:** Please submit a *Dependent Certification* form for dependents aged 19-24.

	Relationship	Dependent Name	Sex	Date of Birth	Office Use Only
____ 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 and that a Dependent Certification form has been submitted for any dependent between the age of 19-24. 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