

SUBSCRIBER APPLICATION DENTAL/VISION BENEFITS ONLY

SUBSCRIBER	ENROLLMENT TYPE: <input type="radio"/> NEW HIRE <input type="radio"/> REHIRE <input type="radio"/> OPEN ENROLLMENT <input type="radio"/> COBRA	<i>Please print</i>		
	REASON: <input type="radio"/> MARRIAGE <input type="radio"/> LEGAL GUARDIAN <input type="radio"/> TRANSFER <input type="radio"/> LOSS OF COVERAGE	SOCIAL SECURITY NO. _____ NAME (LAST, FIRST, MIDDLE INITIAL) _____		
	DISTRICT NAME _____	BIRTH DATE OF EMPLOYEE (MM/DD/YY) _____	MARITAL STATUS _____	GENDER _____
	ACCOUNT # _____	ADDRESS _____	CITY _____	STATE _____ ZIP CODE _____
	EFFECTIVE DATE _____	JOB TITLE/OCCUPATION _____		EMPLOYMENT DATE (REQUIRED) _____
		HOURS WORKED/WEEK _____	ANNUAL SALARY _____	

DEPENDENTS	NAME: (FIRST, LAST IF DIFFERENT)	GENDER	SOCIAL SECURITY NO. (MANDATORY FOR ALL)	BIRTHDATE MM/DD/YY	OTHER INSURANCE?	CHECK IF APPLICABLE
	SPOUSE				<input type="radio"/> YES <input type="radio"/> NO	<input type="radio"/> AGE 19-26 <input type="radio"/> DISABLED
	CHILD				<input type="radio"/> YES <input type="radio"/> NO	<input type="radio"/> AGE 19-26 <input type="radio"/> DISABLED
	CHILD				<input type="radio"/> YES <input type="radio"/> NO	<input type="radio"/> AGE 19-26 <input type="radio"/> DISABLED
	CHILD				<input type="radio"/> YES <input type="radio"/> NO	<input type="radio"/> AGE 19-26 <input type="radio"/> DISABLED

GROUP PLANS	GROUP DENTAL : <input type="radio"/> YES <input type="radio"/> NO <i>If yes,</i> <input type="radio"/> EMPLOYEE <input type="radio"/> EMPLOYEE & DEPENDENT(S)
	DENTAL PLAN NAME/CODE _____
	GROUP VISION : <input type="radio"/> YES <input type="radio"/> NO <i>If yes,</i> <input type="radio"/> EMPLOYEE <input type="radio"/> EMPLOYEE & DEPENDENT(S)
	VISION PLAN NAME/CODE _____

OTHER INSURANCE	Are you or any family member covered under another group insurance program(s)? <input type="radio"/> YES — <i>Please complete below</i> <input type="radio"/> NO			
	NAME OF SUBSCRIBER _____	SOCIAL SECURITY NO. _____	DATE OF BIRTH _____	EMPLOYER _____
				<input type="radio"/> FAMILY <input type="radio"/> SINGLE
	DENTAL INSURANCE COMPANY NAME _____		EFFECTIVE DATE _____	
				<input type="radio"/> FAMILY <input type="radio"/> SINGLE
VISION INSURANCE COMPANY NAME _____		EFFECTIVE DATE _____		

SIGNATURES	<input type="radio"/> I have read and understand the conditions on the reverse side of this form.	
	APPLICANT SIGNATURE _____	DATE _____

Signed form must be received within 30 days of requested effective date.