# Humana Specialty Benefits
# Dental Plan Enrollment/Change Form

| OFFICE USE ONLY: | |
|---|---|
| Mainframe | _____ |
| Online | _____ |
| 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 or Drop Dependent (circle one)** Complete Sections 2, 3, 4, & 5 **Decline or Cancel Plan (circle one)** Complete Sections 2 & 6

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

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

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

3. **Type of Coverage:**

_____ **Employee Only** $29.00 _____ **Employee/Child(ren)** $70.00 _____ **Employee/Spouse** $74.00 _____ **Employee/Family** $87.00

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 during the annual NEISD open enrollment period.

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 8/2013