ENROLLMENT/CHANGE FORM — LEGISLATOR/DENTAL

VERMONT
DEPARTMENT OF HUMAN RESOURCES

Return all completed forms to:
STATE OF VERMONT
EMPLOYEE BENEFITS UNIT
120 STATE STREET, 5th floor
MONTPELIER, VT 05620-2505

❖ EMPLOYEE INFORMATION

Name: _____ **Employee ID:**_____

Date of Birth:_____ **SSN:** _____

Home Phone:_____ **Work Phone:**_____

Address: _____

_____

❖ ACTION REQUEST

☐ **New Hire** ☐ **Open Enrollment** ☐ **Remove/Add Dependent** ☐ **Cancel Coverage**

If Add/Remove, please give reason and effective date (i.e. Birth, Death, Marriage, Divorce and Date)

_____

_____

❖ STATUS

☐ **Single** ☐ **Married** ☐ **Domestic Partner** ☐ **Widowed** ☐ **Divorced** ☐ **Dissolution Domestic Partnership or Civil Union** **If status has changed, please provide date of event** _____

❖ BENEFITS

☐ **I select the DENTAL coverage to the right.**

#2. CHOOSE COVERAGE

☐ **Employee Only**
☐ **Two Person**
☐ **Family (Employee + 2 or more)**

PLEASE PROVIDE ALL REQUESTED INFORMATION BELOW AND SIGN THE NEXT PAGE

❖ YOU & DEPENDENTS

RELATIONSHIP CODES: Spouse = SP; Child = CH; Domestic or Civil Union Partner = NQP

Fill in your own information on the first line. Your dependents include your spouse, civil union partner, qualified domestic partner, unmarried children under age 26, including children of your civil union or qualified domestic partner.

	Coverage Election Dental	Person Has Other Insurance
Employee Coverage	☐ Y ☐ N	☐ Y ☐ N

	Coverage Election Dental	Person Has Other Insurance	
Name: _____	☐ Y ☐ N	☐ Y ☐ N	
Relationship: _____	**Date of Birth:** _____	☐ **Male** ☐ **Female**	**SSN:** _____

Coverage Election Dental | **Person Has Other Insurance**

Name: ________________ ☐ Y ☐ N ☐ Y ☐ N

Relationship: ____________ **Date of Birth:** __________ ☐ **Male** ☐ **Female** **SSN:** __________________

Coverage Election Dental | **Person Has Other Insurance**

Name: ________________ ☐ Y ☐ N ☐ Y ☐ N

Relationship: ____________ **Date of Birth:** __________ ☐ **Male** ☐ **Female** **SSN:** __________________

Coverage Election Dental | **Person Has Other Insurance**

Name: ________________ ☐ Y ☐ N ☐ Y ☐ N

Relationship: ____________ **Date of Birth:** __________ ☐ **Male** ☐ **Female** **SSN:** __________________

Coverage Election Dental | **Person Has Other Insurance**

Name: ________________ ☐ Y ☐ N ☐ Y ☐ N

Relationship: ____________ **Date of Birth:** __________ ☐ **Male** ☐ **Female** **SSN:** __________________

Coverage Election Dental | **Person Has Other Insurance**

Name: ________________ ☐ Y ☐ N ☐ Y ☐ N

Relationship: ____________ **Date of Birth:** __________ ☐ **Male** ☐ **Female** **SSN:** __________________

Coverage Election Dental | **Person Has Other Insurance**

Name: ________________ ☐ Y ☐ N ☐ Y ☐ N

Relationship: ____________ **Date of Birth:** __________ ☐ **Male** ☐ **Female** **SSN:** __________________

FOR MORE DEPENDENTS USE SECOND FORM

I understand that any medical information that is pertinent and necessary for the payment of claims for me or my eligible dependents can be used in accordance with the privacy rules established by the Health Insurance Portability and Accountability Act. I certify that the above information is complete and correct and that all claims submitted will only be for eligible plan members.

SIGNATURE: ____ **DATE:** _______________________