ENROLLMENT/CHANGE FORM  **LEGISLATOR DENTAL**

LEGISLATOR DENTAL PLAN ENROLLMENT FORM

❖ EMPLOYEE INFORMATION

Name: _____

Date of Birth: _____

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

Address: _____

Complete fillable form, save as a PDF and email to:

Mike Ferrant
mferrant@leg.state.vt.us

❖ 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** _____

YOU ARE REQUIRED TO SUBMIT PROOF OF QUALIFYING EVENT TO ADD DEPENDENTS
(E.g. Marriage License, Birth Certificate, Adoption Verification, Domestic Partner Application)

DENTAL COVERAGE (check one)

☐ 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 dental 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.

EMPLOYEE SIGNATURE: ____ **DATE:** __________________________