



# Sample Company –2012 Dental Enrollment Form

Effective Date: 1/1/2012

Your selection will apply to all covered family members:  New Enrollment  Change  Decline all Coverage

### Dental Plan

- 100% of the first \$200
- 50% of the next \$2,600
- \$1,500 annual maximum per person
- Orthodontics are covered for adults and children with no lifetime maximum

Employee \_\_\_\_\_

Social Security No \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Birth Date \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone No \_\_\_\_\_ E-mail \_\_\_\_\_

### Coverage - please check one:

- Employee Only  Employee + 1  Employee + Spouse  Employee + Child(ren)  Family

**Dependents (list only if they are to be covered):** Dependents include: Spouse, children under age 19, or if a full-time student, under age 26 if shown as your legal dependent, or a disabled child in your care.

	Name	Birth date	Relationship	Social Security
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____
6.	_____	_____	_____	_____

If requesting benefits, I agree that my contributions will be paid through a salary reduction agreement and I authorize the necessary pay reduction for benefits. I agree that I cannot change my election until the next plan anniversary date unless there is a change in family status (divorce, marriage, death, additional children).

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

**For Employer Use Only:** Email completed forms to: [eligibility@simple.us](mailto:eligibility@simple.us) or fax to: 678-258-8299

Questions? Call Customer Service at 800-270-4158

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