ADN ADMINISTRATORS

MACOMB ISD DENTAL ENROLLMENT FORM

Eligibility/Change/Termination Report **Union/Division:_____**

General Information Employee

Name (Last) (First) (Middle) Sex Birth Date Social Security #

Address (Street) City State Zip Code

Occupation Hire Date Effective Date Plan

Section 2 Dependent Information

Name (Last)	(First)	(Middle)	Sex	Date of Birth	Relationship	Effective Date

Is there a court order requiring coverage for any dependent in the case of divorced or legally separated parents? ——Yes —— No

Section 3 Change/Correction

A. Name Change

	Last Name	First Name	Social Security #	Effective Date
Employee: From: To:				
Dependents: From: To:				

B. Termination of Benefits
Employee Effective Date of Termination _____

Dependent Effective Date of Termination: _____

Spouse: _____

Dependent(s): _____

C. Additional Coverage - Will this enrollment result in coverage under more than one dental program for you or your spouse? Yes____☐____ No____☐____

Signature_____Date_____