DENTAL / VISION INSURANCE ENROLLMENT FORM
for Upper Dauphin Area School District

EMPLOYER (GROUP) NAME
Upper Dauphin Area School District

EMPLOYEE LAST NAME	FIRST	MI	DATE OF BIRTH

STREET ADDRESS, CITY, STATE, ZIP

SOCIAL SECURITY NUMBER

DATE OF HIRE

GENDER
☐ Male
☐ Female

EFFECTIVE DATE OF COVERAGE

Vision **CONTRACT TYPE REQUESTED** ***(See Reverse Side for Plan Details)*** **Dental**

Vision	Dental
☐ Employee Only	☐ Employee Only
☐ Family	☐ Family

Important Information Regarding Coverage:

Canceling Coverage. An employee may elect to cancel coverage during the District's open enrollment period as long as the coverage has been maintained for a minimum of 12 consecutive months leading up to the enrollment change, unless there is a qualifying event.

Should a qualifying event (as defined under COBRA) occur, for purposes of enrollment or cancellation, the employee must request the change no later than 30 days after the qualifying event. Examples of qualifying events include change in marital status, change in dependents status, loss of job.

COMPLETE THE FOLLOWING FOR ALL FAMILY MEMBERS FOR WHOM YOU ARE REQUESTING COVERAGE

PLEASE CHECK THE APPROPRIATE ENROLLMENT COVERAGE

ADDING COVERAGE FOR: (CHECK ALL THAT APPLY) ☐ **EMPLOYEE** ☐ **SPOUSE**

☐ **DEPENDENT(S) (Covered to age 26 regardless of student status)**

LAST NAME	FIRST NAME	INITIAL	GENDER	DATE OF BIRTH
Spouse				
Dependent				
Dependent				
Dependent				
Dependent				
Dependent				

ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST ANY INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

I HEREBY APPLY FOR ENROLLMENT FOR COVERAGE.

EMPLOYEE SIGNATURE: **X** _____ DATE: _____