

SANTA BARBARA COUNTY SELF-FUNDED DENTAL PLAN ENROLLMENT/CHANGE FORM



PLEASE PRINT

Group No. NP8059		Social Security No.			Last Name			First Name			Initial
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth MM DD YY		Street Address			City		State	Zip Code		
Name of Employer				Location			Work Phone ()				
Department #		Department Name			Job Title		Date of Regular Employment MM DD YY				
Marital Status		<input type="checkbox"/> Single		<input type="checkbox"/> Married		<input type="checkbox"/> Widowed		<input type="checkbox"/> Divorced		Dependent Children	<input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, #

New Enrollment
 Name/Address Change
 Decline Coverage
 Termination/Retirement
 Annual Enrollment
 Add/Drop Coverage
 Reinstatement
 Rehire
 Effec. date: / / /

Transfer from: _____ to _____
 Effec. date: / / /

Family Status Change: _____
 Effec. date: / / /

Is there a court decree that declares which parent is to provide insurance for any of the above dependents? Yes No
 If "Yes," please attach a copy of that section of the court decree.

List name, relationship to you, date of birth and Social Security Number of each dependent to be covered or terminated. PLEASE LIST ADDITIONAL DEPENDENTS ON A SEPARATE SHEET.							Give policy number, name and address of other carrier, (including Medicare), that you or your dependents may have been insured with in the past 6 months indicate effective and termination dates.	If a dependent child is between the ages of 19 and 23 and is at least 50% financially dependent upon you, please indicate with a check mark.
Name	Relationship			Date of Birth	Sex	Social Security Number		
	Self	Sp.	Ch.	MM/DD/YY				
SELF	X						DO NOT COMPLETE	

HOME OFFICE USE ONLY	<input type="checkbox"/> Employee only <input type="checkbox"/> Employee+1 <input type="checkbox"/> Employee+2 or more
Effective Date of Coverage MM DD YY _____ / _____ / _____	

AUTHORIZATION

- I hereby certify that all information furnished is true to the best of my knowledge.
- I request group insurance for which I am or may become eligible.
- If I am required to contribute to the premium for any coverage elected on this form, I hereby authorize my employer to deduct such contributions from wages due me, for remittance to Golden West Dental & Vision.

_____/_____/_____
DATE SIGNED

- I authorize my physician or medical professional, any hospital, clinic, any insurer or employer to give Golden West Dental & Vision or any consumer reporting agency acting on its behalf, information about me for the exclusive purpose of administrating the dental program. Such information will pertain to my employment, other insurance coverage and medical care, advice, treatment or supplies for any physical or medical condition.

APPLICANT'S SIGNATURE