_____New Hire _____Open Enrollment

Hopkins County Board of Education
Delta Dental Enrollment/Status Change Form

EMPLOYEE'S NAME _____
Last First Middle Initial

ADDRESS _____

_____
CITY STATE ZIP CODE

SOCIAL SECURITY NUMBER: ___ ___ ___- ___ ___- ___ ___ ___ ___

____MALE ____FEMALE DATE OF BIRTH: __ __- __ __- __ __ **DATE OF HIRE:** __ __- __ __- __ __
***only for new hires**

COVERAGE STATUS DESIRED:

Employee Only _____ **No Charge**

Spouse Only –OR- One Child Only _____ **$27.12 per month (1 dependent covered)**

Spouse and 1 Child –OR- Two Children _____ **$32.54 per month (2 dependents covered)**

Spouse and 2 + Children –OR- 3+Children _____ **$43.40 per month (3 or more dependents) covered**

PLEASE LIST ALL ELIGIBLE DEPENDENTS THAT YOU WISH TO COVER.
WHEN MAKING CHANGES, PLEASE INDICATE IN THE COLUMN ON THE LEFT IF YOU ARE ADDING OR DROPPING DEPENDENTS.

ADD or REMOVE	Dependent	First Name MI Last Name	Date of Birth	Social Security Number
	SPOUSE			
	CHILD			
	CHILD			
	CHILD			
	CHILD			
	CHILD			

***Children are eligible for coverage up to age 26**

I authorize my employer to deduct from my earnings the amount required to cover my share of the coverage I have selected.

I authorize the payroll reductions to be a Section 125 Before-Tax contribution. Changes in the cafeteria plan elections can only be made at the end of the plan year unless due to and consistent with a valid status change (e.g., change in legal marital status; change in number of dependents; termination or commencement of employment).

SIGNATURE _____ **DATE** _____