OSSEO AREA SCHOOLS
ISD 279

Dental Enrollment/Change Form

Effective _____

SECTION 1 - EMPLOYEE INFORMATION (Please complete in full and print clearly.)

Employee Last Name	First MI	Social Security #	
Street Address		Home Phone Number	
City	State Zip Code	Date of Birth / /	Employee Number
Contract/Benefit Group:			

SECTION 2 - PLAN(S) AFFECTED BY CHANGE

☒ Dental only

SECTION 3 - REASON FOR CHANGE

☐ New Hire/Return from Leave
☐ Dropping Dependents
☐ Adding Dependents
☐ Declining Coverage
☐ Other _____

SECTION 4 – EMPLOYEE AND DEPENDENT INFORMATION

Add	Drop	Relationship to Employee	First Name, Middle initial (last name only if different than employee last name)	Gender	Date of Birth	Social Security #

SECTION 5 - EMPLOYEE SIGNATURE

I understand that this election cannot be revoked or changed until the next open enrollment period, unless there is a loss of eligible or life event. The change must be made within 30 days from the date of the life event. (Please contact your Human Resources generalist or refer to the benefits booklet for the life event information.

_____ _____

EMPLOYEE SIGNATURE DATE SIGNED

For HR use only

TIES: _____ Delta Dental: _____

Updated 6/2015