



OFFICE USE ONLY

Send this completed form to:
 Employee Benefits
 Human Resources Bldg.
 215 S. Jackson St.
 Athens, GA 30602-4133

APPLICANT'S NAME Last First MI	Social Security Number
Complete home address	Daytime phone (Include area code) Email address

Check coverage change you wish to make (indicate reason at right: **Reason for change in coverage and date of qualifying event:**)

You must submit appropriate documentation to support the change, with the exception of "dependent no longer eligible."

Individual
 Individual + child
 Individual + spouse
 Family
 Cancel coverage
 Other _____

Below, complete the information requested for any individuals being added or deleted.

Change in your spouse's employment status (documentation required)
 Marriage (documentation required)
 Divorce (documentation required)
 Birth/adoption of dependent (documentation required)
 Death of dependent (documentation required)
 Dependent no longer eligible
 Other _____

DATE OF EVENT		
Mo.	Day	Year

Signature required *Date signed*

✓ If adding or deleting dependents or spouse, enter ONLY the information pertaining to the individuals being added or deleted.

Add	Delete	Last name	First name		Gender	Birthdate		
						Month	Day	Year
				<input type="checkbox"/> SPOUSE	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE			
Children						Complete if child is over 19		
				<input type="checkbox"/> NATURAL or ADOPTED <input type="checkbox"/> <input type="checkbox"/> STEP _____	<input type="checkbox"/> STUDENT* <input type="checkbox"/> DISABLED	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		
				<input type="checkbox"/> NATURAL or ADOPTED <input type="checkbox"/> <input type="checkbox"/> STEP _____	<input type="checkbox"/> STUDENT* <input type="checkbox"/> DISABLED	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		
				<input type="checkbox"/> NATURAL or ADOPTED <input type="checkbox"/> <input type="checkbox"/> STEP _____	<input type="checkbox"/> STUDENT* <input type="checkbox"/> DISABLED	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		
				<input type="checkbox"/> NATURAL or ADOPTED <input type="checkbox"/> <input type="checkbox"/> STEP _____	<input type="checkbox"/> STUDENT* <input type="checkbox"/> DISABLED	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		

*Complete an "Application for Unmarried Dependent Student" form for children over age 19, available at: <http://www.hr.uga.edu/benefits/ben2.html>

Are you or your spouse covered under any other group/employer dental insurance program?
 Yes No

If yes, complete sections A through C below.

Information regarding the University System of Georgia dental plan benefits is available at: <http://www.usg.edu/employment/benefits/>

A. Name of insurance co. (s) & employer(s)
 Self _____ Spouse/dependent _____

B. Effective date(s) of policy(ies) & contract numbers

C. Type of contract Self only Family