

Dental Insurance • Enrollment/change • Retirees only

Check one:

- Cancel all coverage**
- Drop dependents** (Below, list **all** dependents you wish to delete.)
- Add dependents*** (Provide reason at right. Below, list **all** dependents you wish to add.)
- Enroll*** (Provide reason at right. Below, list **all** individuals you wish to cover.)

*Sorry, retirees may not enroll in dental insurance or add dependents during open enrollment.

Reason for change

- You must provide documentation to support the change selected below.
- Marriage
- Divorce
- Birth/adoption of dependent
- Death of dependent
- Dependent no longer eligible (no documentation required)
- Other: _____

DATE OF EVENT		

OFFICE USE ONLY

APPLICANT'S NAME Last First MI		Social Security Number	Send this completed form to: Employee Benefits Human Resources Bldg. 215 S. Jackson St. Athens, GA 30602-4133
MAILING ADDRESS (Include city, state, zip)		COUNTY	
DATE OF BIRTH Mo. Day Year	EMAIL ADDRESS	DAYTIME PHONE	Coverage desired <input type="checkbox"/> Retiree only <input type="checkbox"/> Retiree + child <input type="checkbox"/> Retiree + spouse <input type="checkbox"/> Family
		<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widow(ed) <input type="checkbox"/> Separated	

Retiree signature _____ Date signed _____

List ALL eligible dependents you wish to delete. For eligibility information, refer to the Dental Plan booklet:
<http://www.usg.edu/employment/benefits/dental>

Add	Delete	Last name	First name	Relationship	Gender	Month	Day	Year
	2.			<input type="checkbox"/> SPOUSE	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE			
Children								
	3.			<input type="checkbox"/> NATURAL or ADOPTED <input type="checkbox"/> <input type="checkbox"/> STEP _____	<input type="checkbox"/> STUDENT* <input type="checkbox"/> DISABLED			
	4.			<input type="checkbox"/> NATURAL or ADOPTED <input type="checkbox"/> <input type="checkbox"/> STEP _____	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE			
	5.			<input type="checkbox"/> NATURAL or ADOPTED <input type="checkbox"/> <input type="checkbox"/> STEP _____	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE			
	6.			<input type="checkbox"/> NATURAL or ADOPTED <input type="checkbox"/> <input type="checkbox"/> STEP _____	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE			
	7.			<input type="checkbox"/> NATURAL or ADOPTED <input type="checkbox"/> <input type="checkbox"/> STEP _____	<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.

A. Name of insurance co. (s) & employer(s)

Self _____ Spouse _____

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

C. Type of contract Self only Family