

Dental Insurance

SURVIVING DEPENDENT

- I wish to continue dental coverage
- I refuse coverage
(Complete box below and return form to Employee Benefits)

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

• FOR BENEFITS USE ONLY •

Coverage desired

- Applicant only
- Applicant + child
- Applicant + spouse
- Family

APPLICANT'S NAME Last First MI		Social Security Number	
BILLING ADDRESS (Include city, state, zip)			County
HOME ADDRESS (if different from billing address) (Include city, state, zip)			Home phone (include area code)
DATE OF BIRTH Mo. Day Year	Name of deceased retiree/employee	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Widow(ed) <input type="checkbox"/> Dependent
DATE OF DEATH OF RETIREE/EMPLOYEE Mo. Day Year	SS # of deceased		

Your premiums will be billed monthly by the University of Georgia. Payments for insurance premiums are due by the tenth of the month following the billing date.

Applicant signature _____

Date signed _____

List all eligible individuals you wish to cover.

	Last name	First name		Gender	Birthdate		
					Month	Day	Year
2.			<input type="checkbox"/> SPOUSE	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE			
			Children	Complete if child is over 19			
3.			<input type="checkbox"/> NATURAL or ADOPTED <input type="checkbox"/> STEP <input type="checkbox"/> OTHER _____	<input type="checkbox"/> STUDENT* <input type="checkbox"/> DISABLED	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		
4.			<input type="checkbox"/> NATURAL or ADOPTED <input type="checkbox"/> STEP <input type="checkbox"/> OTHER _____	<input type="checkbox"/> STUDENT* <input type="checkbox"/> DISABLED	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		
5.			<input type="checkbox"/> NATURAL or ADOPTED <input type="checkbox"/> STEP <input type="checkbox"/> OTHER _____	<input type="checkbox"/> STUDENT* <input type="checkbox"/> DISABLED	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		
6.			<input type="checkbox"/> NATURAL or ADOPTED <input type="checkbox"/> STEP <input type="checkbox"/> OTHER _____	<input type="checkbox"/> STUDENT* <input type="checkbox"/> DISABLED	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		
7.			<input type="checkbox"/> NATURAL or ADOPTED <input type="checkbox"/> STEP <input type="checkbox"/> OTHER _____	<input type="checkbox"/> STUDENT* <input type="checkbox"/> DISABLED	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		

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

✓ If yes, complete sections A through E below.

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

B. Effective date(s) of policy(ies)

C. Contract number(s)

D. Type of contract Self only Family

E. Name of group(s) (employers)
Self _____
Spouse _____

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

REFUSAL STATEMENT	
I DO NOT want University System of Georgia dental coverage at this time. I understand I will not be able to enroll in the future.	
Name	_____
SS#	_____
Date	_____
Signature	_____
Return this entire form to Employee Benefits	

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