Dickinson

Enrollment/Change Form for Medical, Dental & Vision Insurance

Please print legibly and return completed form to Human Resource Services.

Subscriber Information: ☐ **New Enrollment** ☐ **Change** ☐ **Delete**

Employee First, MI, Last Name (print): _____

Employee Social Security Number: _____-_____-_____

Date of Birth (MM/DD/YYYY): _____/_____/_____ ☐ Male ☐ Female

Address _____

City _____ State _____ Zip Code_____

I elect the following plan(s)

☐ Medical – HealthAmerica/HealthAssurance ☐ Vision – Vision Benefits of America

☐ Dental – Concordia Select – United Concordia ☐ Dental – Concordia Choice – United Concordia

Employee Signature: _____ Date: _____

☐ **ADD** ☐ **DELETE**
Dependent First Name: Dependent Middle Name: Dependent Last Name:
Dependent Social Security Number: _____-_____-_____
Relationship to Employee: ☐ Spouse ☐ Child ☐ Same-Sex Domestic Partner *****   *** Affidavit is Required if Adding Same Sex**
Dependent Date of Birth (MM/DD/YYYY): _____/_____/_____
Dependent Gender: ☐ Male ☐ Female
Enroll/Delete above dependent in the following insurance plan(s): ☐ Medical ☐ Dental ☐ Vision

☐ **ADD** ☐ **DELETE**
Dependent First Name: Dependent Middle Name: Dependent Last Name:
Dependent Social Security Number: _____-_____-_____
Relationship to Employee: ☐ Child
Dependent Date of Birth (MM/DD/YYYY): _____/_____/_____
Dependent Gender: ☐ Male ☐ Female
Enroll/Delete above dependent in the following insurance plan(s): ☐ Medical ☐ Dental ☐ Vision

☐ **ADD** ☐ **DELETE**		
Dependent First Name:	Dependent Middle Name:	Dependent Last Name:
Dependent Social Security Number: __________-_____________-___________		
Relationship to Employee: ☐ Child		
Dependent Date of Birth (MM/DD/YYYY): __________/____________/__________		
Dependent Gender: ☐ Male ☐ Female		
Enroll/Delete above dependent in the following insurance plan(s): ☐ Medical ☐ Dental ☐ Vision		

☐ **ADD** ☐ **DELETE**		
Dependent First Name:	Dependent Middle Name:	Dependent Last Name:
Dependent Social Security Number: __________-_____________-___________		
Relationship to Employee: ☐ Child		
Dependent Date of Birth (MM/DD/YYYY): __________/____________/__________		
Dependent Gender: ☐ Male ☐ Female		
Enroll/Delete above dependent in the following insurance plan(s): ☐ Medical ☐ Dental ☐ Vision		

☐ **ADD** ☐ **DELETE**		
Dependent First Name:	Dependent Middle Name:	Dependent Last Name:
Dependent Social Security Number: __________-_____________-___________		
Relationship to Employee: ☐ Child		
Dependent Date of Birth (MM/DD/YYYY): __________/____________/__________		
Dependent Gender: ☐ Male ☐ Female		
Enroll/Delete above dependent in the following insurance plan(s): ☐ Medical ☐ Dental ☐ Vision		

Authorization:

I certify that the information provided is true and correct. Falsification of information may lead to corrective action up to and including termination of employment.

HR Services USE ONLY

Effective Date of Coverage or Change for Insurance: ___________________

Reviewed By: _____________________________ Date: __________________