Dickinson

Enrollment/Change Form for Medical, Dental & Vision Insurance

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

Subscriber Information:

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

Employee Social Security Number: _____

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

Address _____

City _____ State _____ Zip Code_____

Please choose from the following:

Medical – Aetna:	☐ **New Enrollment**	☐ **Cancel**
Vision – Vision Benefits of America:	☐ **New Enrollment**	☐ **Cancel**
Dental Low Option– United Concordia:	☐ **New Enrollment**	☐ **Cancel**
Dental High Option– United Concordia:	☐ **New Enrollment**	☐ **Cancel**

Employee Signature: _____ **Date:** _____

Dependent First, Middle, Last Name:	Medical: ☐ Add ☐ Cancel
Dependent Social Security Number:	Vision: ☐ Add ☐ Cancel
Relationship to Employee: ☐ Spouse ☐ Child	
Dependent Date of Birth (MM/DD/YYYY):	Dental - Low Option ☐ Add ☐ Cancel
Dependent Gender: ☐ Male ☐ Female	Dental - High Option ☐ Add ☐ Cancel

Dependent First, Middle, Last Name:	Medical: ☐ Add ☐ Cancel
Dependent Social Security Number:	Vision: ☐ Add ☐ Cancel
Relationship to Employee: ☐ Child	
Dependent Date of Birth (MM/DD/YYYY):	Dental - Low Option ☐ Add ☐ Cancel
Dependent Gender: ☐ Male ☐ Female	Dental - High Option ☐ Add ☐ Cancel

Dependent Information	Coverage
Dependent First, Middle, Last Name:	Medical: ☐ Add ☐ Cancel
Dependent Social Security Number:	Vision: ☐ Add ☐ Cancel
Relationship to Employee: ☐ Child	Dental - Low Option ☐ Add ☐ Cancel
Dependent Date of Birth (MM/DD/YYYY):	
Dependent Gender: ☐ Male ☐ Female	Dental - High Option ☐ Add ☐ Cancel

Dependent Information	Coverage
Dependent First, Middle, Last Name:	Medical: ☐ Add ☐ Cancel
Dependent Social Security Number:	Vision: ☐ Add ☐ Cancel
Relationship to Employee: ☐ Child	Dental - Low Option ☐ Add ☐ Cancel
Dependent Date of Birth (MM/DD/YYYY):	
Dependent Gender: ☐ Male ☐ Female	Dental - High Option ☐ Add ☐ Cancel

Dependent Information	Coverage
Dependent First, Middle, Last Name:	Medical: ☐ Add ☐ Cancel
Dependent Social Security Number:	Vision: ☐ Add ☐ Cancel
Relationship to Employee: ☐ Child	Dental - Low Option ☐ Add ☐ Cancel
Dependent Date of Birth (MM/DD/YYYY):	
Dependent Gender: ☐ Male ☐ Female	Dental - High Option ☐ Add ☐ Cancel

<u>Authorization:</u>

I certify that the infomation 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: __________________