ENROLLMENT APPLICATION

INDICATE REASON FOR APPLICATION:

New Enrollment

Date of Hire: ________________

Add Dependent

Date of Marriage:______________

Date of Birth:_________________

Date of Adoption:______________

Late Enrollment

Received Date:_____________________

Change Address/Name

Decline Dental and Vision Coverage

____

Signature Date

GROUP NO. 4402-0001

SOCIAL SECURITY #	ED	LAST NAME FIRST NAME MI			HOME PHONE ( )
MAILING ADDRESS	CITY	STATE	ZIP	COUNTY	BIRTHDATE / /
MARRIED: Yes No			SEX: M F		
DEPARTMENT NAME			DATE EMPLOYED		
TRINITY COUNTY PAYS THE ENTIRE PREMIUM FOR DENTAL COVERAGE, INCLUDING FAMILY COVERAGE.					
THERE IS A PAYROLL DEDUCTION OF $12.35 PER MONTH FOR FAMILY VISION COVERAGE.					
ARE YOU COVERING YOUR DEPENDENTS? No Yes (IF YES, PLEASE COMPLETE THE FOLLOWING INFORMATION)					

RELATION TO EMPLOYEE	LAST NAME	FIRST NAME MI	DATE OF BIRTH	SEX (M/F)	DENT. VISION
Self					
Spouse					
Dependent Child					
Dependent Child					
Dependent Child					

DO YOU HAVE ANY OTHER DENTAL COVERAGE? NO YES SELF SPOUSE CHILDREN
(IF YES, PLEASE COMPLETE THE FOLLOWING INFORMATION)

NAME OF INSURED	SOCIAL SECURITY NUMBER	NAME OF OTHER INSURANCE COMPANY	GROUP NO.	
EMPLOYER OF INSURED	EMPLOYER ADDRESS	CITY	STATE	ZIP

IF YOUR SPOUSE HAS OTHER DENTAL COVERAGE, ARE DEPENDENTS ENROLLED UNDER SPOUSE'S PLAN? NO YES

My signature below indicates acceptance and/or changes and that the information I have entered above is true and correct.

______________________________________ ______________________

Employee Signature **Date Signed**