

# EASTERN MICHIGAN UNIVERSITY 2012 OPEN ENROLLMENT

## Dental Enrollment/Change Form

*Please print all information clearly.*

### Faculty/Staff Information

Name (Last, First, Middle Initial)		Employee ID	SS#	Work Phone
<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Single <input type="checkbox"/> Married	Email Address: _____ @emich.edu		Home Phone
Address		New? <input type="checkbox"/> Yes <input type="checkbox"/> No	City	State
			Zip	Date of Birth

**Date of Event:** \_\_\_\_\_ **NOTE:** This form must be received by the Benefits Office **within 30 days** of the event.

**Enroll/Add/Change**

- Enroll/New Hire
- Marriage
- Birth/Adoption
- Additional Eligible Adult
- Legal Guardianship
- Principal Support
- Other: \_\_\_\_\_

**Delete**

- Divorce
- Dependent
- Death
- Termination
- Other: \_\_\_\_\_

**Cancel**

- Cancel coverage for me and my dependents.

**Reason:** \_\_\_\_\_  
\_\_\_\_\_

**Dependent Information** - You must complete the following section for all additions and/or deletions. Enter the information for each dependent, and then write **A** in the appropriate benefit column to add to your coverage or **D** to delete from your coverage, or **C** to change.

Name (Last, First, Middle Initial)	Social Security Number	Relationship Code <sup>1</sup>	Gender (M/F)	Date of Birth MM/DD/YY	Dental

<sup>1</sup>Relationship Code - SP = Spouse; D = Dependent; DD = Disabled Dependent; AEA = Additional Eligible Adult; SD = Sponsored Dependent Rider  
**Coverage for dependents is only allowed when certain criteria are met. Proof of eligibility may be required.**

**Certification and Signature** - I have read and agree to the terms and conditions listed on the back of this form. The information provided above is correct to the best of my knowledge.

\_\_\_\_\_  
Signature of Faculty or Staff Member

\_\_\_\_\_  
Date Signed

*Department Use Only:*

*Dental Group: 1873-\_\_\_\_\_ Transfer to \_\_\_\_\_*

*Eff. Date: January 1, 2012*