

Standalone Comprehensive Dental & Vision - DM/GM



First Name

Last Name

Marital Status

Email

Phone

Address

City

State

ZIP

Date of Birth

SSN

Hire Date

Tobacco Use (Yes / No)

Please Select The Coverage(s) You Would Like To Enroll In.

Comprehensive Dental Coverage

- ☐ Employee Only: \$25.58/month
☐ Employee + Spouse: \$73.62/month
☐ Employee + Child(ren): \$68.89/month
☐ Employee + Family: \$124.41/month
☐ No Coverage

Vision Coverage

- ☐ Employee Only: \$7.48/month
☐ Employee + Spouse: \$19.42/month
☐ Employee + Child(ren): \$20.42/month
☐ Employee + Family: \$36.37/month
☐ No Coverage

Enter Dependent Names

First Name

Last Name

Gender

Relationship

Date of Birth

SSN

First Name

Last Name

Gender

Relationship

Date of Birth

SSN

First Name

Last Name

Gender

Relationship

Date of Birth

SSN

First Name

Last Name

Gender

Relationship

Date of Birth

SSN

Authorization and Request for Coverage

I hereby enroll or decline as indicated above in the benefits for which I am eligible.

I acknowledge and understand that the cost for any and all benefits I enroll in will be deducted from my payroll.

Total Cost

Signature
