Standalone Comprehensive Dental & Vision - FT

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: $30.69/month
- ☐ Employee + Spouse: $78.74/month
- ☐ Employee + Child(ren): $74.01/month
- ☐ Employee + Family: $129.53/month
- ☐ No Coverage

Vision Coverage

- ☐ Employee Only: $8.97/month
- ☐ Employee + Spouse: $20.92/month
- ☐ Employee + Child(ren): $21.92/month
- ☐ Employee + Family: $37.87/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