Group Insurance Enrollment & Change Form

☐ **New Hire** ☐ **Open Enrollment** ☐ **Add Dependent** ☐ **Delete Dependent** ☐ **Terminate Coverage** ☐ **RETIREE**

PLANHOLDER NAME (COMPANY NAME) **Jefferson County Commission**				GROUP PLAN NO. **16059**
EMPLOYEE'S NAME (LAST, FIRST, MIDDLE INITIAL)		SOC. SEC. NO.	BIRTHDATE	GENDER
EMPLOYEE'S STREET ADDRESS	CITY	STATE **AL**	ZIP	TELEPHONE NUMBER
COMMENTS/NOTES		OCCUPATION		DEPARTMENT

MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ LEGALLY SEPARATED ☐ DIVORCED

DEPENDENT CHILDREN ☐ YES ☐ NO

DENTAL COVERAGE ELECTION:

EMPLOYEE: ☐ **EMPLOYEE + 1:** ☐ **FAMILY:** ☐

If declining dental coverage, are you covered under another plan? ☐ YES ☐ NO

If declining dental coverage for your spouse or dependents, are they covered under another Plan ☐ YES ☐ NO

DEPENDENT INFORMATION

NAME (LAST, FIRST, MIDDLE INITIAL)	BIRTHDATE	RELATIONSHIP	GENDER	Add / Delete
				☐ ☐
				☐ ☐
				☐ ☐
				☐ ☐
				☐ ☐
				☐ ☐
				☐ ☐

Are any dependent children adopted? ☐ Yes ☐ No If "yes," indicate name(s) and date of adoption:

Have you included stepchildren as dependents? ☐ Yes ☐ No If "yes," indicate name(s):

Do your stepchildren reside with you? ☐ Yes ☐ No Are they dependent upon you for support and maintenance? ☐ Yes ☐ No

o I hereby apply for the group benefits(s) indicated above.
o I understand that my election can not be changed during the year unless I experience a qualifying event.
o I understand I must be actively at work or my coverage will not take effect.
o I authorize my employer to take deductions that may be required for the cost of this coverage.
o The information provided above is true and correct to the best of my knowledge.
o Any person, who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application files a claim containing false or deceptive statement may be guilty of insurance fraud.

EFFECTIVE DATE OF CHANGE **EMPLOYEE SIGNATURE** **DATE**

PLEASE RETAIN A PHOTOCOPY FOR YOUR RECORDS AND SUBMIT THIS FORM TO DENTAL CARRIER