DENTAL/VISION ENROLLMENT FORM

Name: _____ Phone: _____

Address: _____ Email: _____

City: _____ State: _____ Zip: _____

_____Male _____Female DOB: _____/_____/_____ SS#: _____-_____-_____

Dental Coverage Desired? (circle) YES NO
(Check Applicable Rate Below)

DENTAL RATES:	***CLASS 1***	***CLASS 2***
Individual	_____ $28.11	_____ $32.87
Individual & Spouse	_____ $55.68	_____ $65.12
Individual & Child(ren)	_____ $75.58	_____ $90.68
Individual & Family	_____ $103.16	_____ $122.93

Vision Coverage Desired? (circle) YES NO
(Check Applicable Rate Below)

VISION RATES:	
Individual	_____ $9.04
Individual & Spouse	_____ $18.07
Individual & Child(ren)	_____ $19.87
Individual & Family	_____ $28.91

Eligible Dependents:

	SEX (M or F)	***First and Last Name***	***DOB***	***SS #***
1. Spouse	_____	_____	_____/_____/_____	_____/_____/_____
2. Child	_____	_____	_____/_____/_____	_____/_____/_____
3. Child	_____	_____	_____/_____/_____	_____/_____/_____
4. Child	_____	_____	_____/_____/_____	_____/_____/_____
5. Child	_____	_____	_____/_____/_____	_____/_____/_____

Signature: _____ Date: _____/_____/_____

For More Information or Questions, Please contact:
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