

BOR DENTAL INSURANCE – REQUEST FOR CHANGE

LAST NAME	FIRST NAME	MIDDLE INITIAL	SEX	BIRTH DATE
HOME ADDRESS		CITY	COUNTY	STATE ZIP CODE
SOCIAL SECURITY #	DATE OF HIRE	HOME PHONE		WORK PHONE

<p>▲ CANCEL COVERAGE** CHECK REASON FOR CHANGE</p> <p><input type="checkbox"/> ENROLLMENT CHANGE . WITHIN 30 DAYS (NEW HIRE) .</p> <p><input type="checkbox"/> OTHER _____</p>	<p>▲ ADD DEPENDENTS CHECK REASON FOR CHANGE</p> <p><input type="checkbox"/> MARRIAGE: DATE _____</p> <p><input type="checkbox"/> BIRTH: DATE _____</p> <p><input type="checkbox"/> ADOPTION: DATE _____</p> <p><input type="checkbox"/> OTHER: _____</p>	<p>▲ DROP DEPENDENTS** CHECK REASON FOR CHANGE</p> <p><input type="checkbox"/> DEATH: DATE _____</p> <p><input type="checkbox"/> DIVORCE: DATE _____</p> <p><input type="checkbox"/> OVER AGE DEPENDENT</p> <p><input type="checkbox"/> OTHER _____</p>
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LAST NAME	FIRST NAME	MI	BIRTH DATE	SEX	SOCIAL SECURITY NUMBER	RELATIONSHIP	FULL-TIME STUDENT

**Dental Affidavit below must be signed when cancelling or dropping coverage

DATE SIGNED _____ SIGNATURE _____ EFFECTIVE DATE _____

DENTAL AFFIDAVIT**

I am aware that once the Board of Regents group dental plan has been dropped for me and/or my dependent(s), I may not enroll again unless the Board of Regents offers an open enrollment for this plan. Currently, we do not anticipate another open enrollment.

Acknowledged:

DATE EMPLOYEE'S SIGNATURE