

**REGENT'S GROUP DENTAL INSURANCE
ENROLLMENT AND PAYROLL DEDUCTION AUTHORIZATION CARD**
The University System of Georgia

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

FAMILY INFORMATION – (only your spouse and dependent children who you wish to be covered should be listed)

LAST NAME	FIRST NAME	MI	BIRTH DATE	SEX	SOCIAL SECURITY NUMBER	RELATIONSHIP	FULL-TIME STUDENT*

* Additional proof of full-time student status is required for dependent children age 19 - 25

DATE SIGNED _____ SIGNATURE _____ EFFECTIVE DATE _____