

Dental Enrollment Form

Name of group (employer): Danville CCSD No. 118

Employee last name, first name, middle initial: (please print) _____

Social Security Number: _____

Address _____

Gender: male female Date of birth (month/date/year): _____

Effective Date of Coverage: _____

Type of coverage selected: Monthly Premiums (please check the appropriate box)

- Low Plan** employee only - \$21.66
 employee + Spouse - \$43.31
 Employee + Child(ren) \$51.86
 Family - \$ 79.39

- High plan** employee only - \$30.44
 employee + Spouse - \$60.87
 Employee + Child(ren) \$78.97
 Family - \$ 118.91

*** Dependent Relationship:** S=spouse, C=child, H=handicapped child, T=student

dependent last name	dependent first name	Social Security Number	gender	* Dependent Relationship	date of birth mm/dd/yyyy
				<input type="checkbox"/> S <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T	/ /
				<input type="checkbox"/> S <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T	/ /
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				<input type="checkbox"/> S <input type="checkbox"/> C <input type="checkbox"/> H <input type="checkbox"/> T	/ /

Employee Signature: _____