Stewartville Public Schools
DENTAL DIRECT REIMBURSEMENT BENEFIT PLAN
CHANGE FORM

PLEASE PRINT OR TYPE -- Check appropriate level of coverage:
COVERAGE REQUESTED: ______ Employee ______ Employee + 1 ______ Employee +2 _______ Family

	Last Name/First Name/Initial	Birth Date mm/dd/yy	Gender (M/F)	Marital Status*	SS #
Employee					
Spouse					

* For Marital Status, indicate S-Single, M-Married, D-Divorced, O-Other

Other Dependents (List only children up to 19 years of age or full-time student dependents up to age 25--see plan for details.)

Employee Address______________________________
City/State/Zip ______________________________
Daytime Phone Number ____________________ Date of Employment ____________________
Effective Date of Coverage ______________________________
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You will be covered under this plan only when this form is completed and returned to the Business Office. Your signature constitutes a request for participation in this plan and certification that all information provided is true and accurate. **Omission of information or provision of false information may result in forfeiture of eligibility for employee and dependents.**

Employee's Signature______________________________ Date ____________

Submit this enrollment to the Business Office within thirty (30) days of eligibility.
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