Dental Enrollment Form

Effective date:

PART A – EMPLOYEE INFORMATION

Last Name	First Name	Middle Initial

Birthdate	Gender

Street Address	Apt. No.	City	State	Zip Code

Phone	Social Security Number

Email

PART B – DENTAL ENROLLMENT INFORMATION

Plan Design Type: Delta Preferred Plan (PPO and Premier Networks)

Coverage Type: (Check one box)	❑ Employee only ❑ Family

PART C – FAMILY INFORMATION

Please complete the following information for each dependent being covered.

Name	Gender	Birthdate	Relationship to Employee	Social Security Number

PART D – SIGNATURE

Signature:	Date:

Please return completed form with original signature to Human Resources. Questions? Benefits@sowashco.org.