WETZEL COUNTY SCHOOLS DENTAL & VISION PLAN

3150 US Route 60, Ona, WV 25545 (304) 781-3911

ENROLLMENT FORM

Please complete this form **IN INK**. Upon receipt of this form in our office, this form will serve as record for you and your covered dependents under the "WETZEL COUNTY SCHOOLS" Dental and Vision Plan. PROCESSING OF CLAIMS WILL BE DELAYED WITHOUT THIS FORM COMPLETED IN ITS ENTIRETY.

NAME _____ **S.S.#** _____
(LAST NAME) (FIRST NAME) (MI)

ADDRESS _____
(STREET) (CITY) (STATE) (ZIP)

DATE OF BIRTH ____/____/____ **MARITAL STATUS:** ☐ S ☐ M ☐ D ☐ W

SEX: ☐ F ☐ M **TELEPHONE** (_____) _____ **DATE OF HIRE** _____

Please indicate your choice of coverage:

☐ **Single Dental & Vision**

☐ **Family Dental & Vision**

Please indicate your status:

☐ **Active**

Dependents to be Covered

NAME	SS #	RELATIONSHIP	DATE OF BIRTH

OTHER INSURANCE INFORMAITON

Is your spouse employed? ☐ Yes ☐ No

If yes, name and address of employer _____

Do you or your dependents have any other group insurance which provides dental/vision benefits? If yes, name of:

Insured _____ Insurance Company _____

Insurance Company Address _____

Type of Change:

Effective Date

☐ New Enrollment _____

☐ Reinstatement _____

☐ Change of Address _____

☐ Name Change (If due to marriage, please give date of marriage _____

☐ Adding Dependent(s)

Termination of Coverage effective _____ due to:

☐ Divorce of Legal Separation

☐ Reduction in Force

☐ No longer qualifies as an Eligible Dependent

_____

☐ Resigned

_____
Signature of Employee

_____
Date

PRINT