

- New
 Change/Reason _____



Effective Date _____

ENROLLMENT APPLICATION

Botetourt County Board of Supervisors Dental Plan
Group#

EMPLOYEE INFORMATION

Employee Name (Last, First, M.I.)	Social Security Number
Date of Birth Mo Day Year	Date Employed Mo Day Year
Address	Phone
City, State, Zip	Marital Status

Please check the coverage option below that you have elected

Dental Coverage Election	
Employee <input type="checkbox"/>	
Employee + Child <input type="checkbox"/>	Child(ren) covered through 19th birthday; or until 25th birthday if full-time student
Employee + Children <input type="checkbox"/>	Child(ren) covered through 19th birthday; or until 25th birthday if full-time student
Employee + Spouse <input type="checkbox"/>	
Employee + Family <input type="checkbox"/>	Child(ren) covered through 19th birthday; or until 25th birthday if full-time student

List All Persons To Be Enrolled For Coverage

Spouse (Last, First, M.I.)	Date of Birth Mo Day Year	Sex		
Dependent (Last, First, M.I.)	Date of Birth Mo Day Year	Sex	F T Student Y <input type="checkbox"/> N <input type="checkbox"/>	Name of School/University Attending
Dependent (Last, First, M.I.)	Date of Birth Mo Day Year	Sex	F T Student Y <input type="checkbox"/> N <input type="checkbox"/>	Name of School/University Attending
Dependent (Last, First, M.I.)	Date of Birth Mo Day Year	Sex	F T Student Y <input type="checkbox"/> N <input type="checkbox"/>	Name of School/University Attending
Dependent (Last, First, M.I.)	Date of Birth Mo Day Year	Sex	F T Student Y <input type="checkbox"/> N <input type="checkbox"/>	Name of School/University Attending

Are you or your dependants covered by any other dental insurance plan Yes No

Employee's Signature

Date

I DECLINE COVERAGE

Are you declining enrollment for yourself or your dependent because you or your dependents have coverage under another dental plan? Yes No

Employee's Signature

Date