USD 498 Waterville School Form

EFFECTIVE DATE:__________________

Employee Information

Last Name ___________________First Name _________________M. Int_____ Date of Birth ___/___/___ Sex M / F Single / Married / Divorced

Social Security Number _______________________ Home Phone Number (____)______________ Date of Hire:____/_____/_____

Address ____ City ____________________ State______ Zip _________

Personal Email Address___________________________________

Family Information

Last Name ___________________________ First Name ______________________ M. Int ________ Sex M / F Date of Birth ____/____/______

Relationship ____________________Soc, Sec. # ___________________ Is dependent's address different than applicants? Y / N (if yes, provide)

Last Name ___________________________ First Name ______________________ M. Int ________ Sex M / F Date of Birth ____/____/______

Relationship ____________________Soc, Sec. # ___________________ Is dependent's address different than applicants? Y / N (if yes, provide)

Last Name ___________________________ First Name ______________________ M. Int ________ Sex M / F Date of Birth ____/____/______

Relationship ____________________Soc, Sec. # ___________________ Is dependent's address different than applicants? Y / N (if yes, provide)

Last Name ___________________________ First Name ______________________ M. Int ________ Sex M / F Date of Birth ____/____/______

Relationship ____________________Soc, Sec. # ___________________ Is dependent's address different than applicants? Y / N (if yes, provide)

DENTAL PLANS—DELTA DENTAL | **VISION PLANS—VISION CARE DIRECT**

Dental 2 EMPLOYEE COST *Per Month*		Silver Materials EMPLOYEE COST *Per Month*	Gold Materials EMPLOYEE COST *Per Month*
☐ $32.35	**EMPLOYEE ONLY**	☐ $7.80	☐ $9.62
☐ $61.90	**EMPLOYEE / SPOUSE**	☐ $12.47	☐ $15.38
☐ $67.58	**EMPLOYEE / CHILD(REN)**	☐ $14.39	☐ $17.75
☐ $98.72	**FAMILY**	☐ $24.46	☐ $30.19
Dental 3 EMPLOYEE COST *Per Month*		**Silver Exam & Materials** EMPLOYEE COST *Per Month*	**Gold Exam & Materials** EMPLOYEE COST *Per Month*
☐ $27.37	**EMPLOYEE ONLY**	☐ $11.63	☐ $13.57
☐ $54.90	**EMPLOYEE / SPOUSE**	☐ $18.72	☐ $21.83
☐ $75.46	**EMPLOYEE / CHILD(REN)**	☐ $21.61	☐ $25.18
☐ $113.74	**FAMILY**	☐ $36.74	☐ $42.84

☐ **WAIVE DENTAL COVERAGE** ☐ **WAIVE VISION COVERAGE**

******PLEASE READ THIS SECTION BEFORE SIGNING THE APPLICATION******

TERMS AND CONDITIONS

1. I authorize deduction from my wage/pension, if necessary for the required premium for the coverage for which I or any dependents have applied.
2. I am responsible to timely notify my employer of any change that would make me or any dependent ineligible for coverage.
3. I understand these elections cannot be changed or revoked prior to the next plan Open Enrollment date, October 1 unless I experience a Qualifying Event. I understand it is my responsibility to contact Human Resources within 31 days if I experience a Qualifying Event.

Read the **TERMS AND CONDITIONS** section above carefully before signing *Please review your application for errors or omissions.*

Applicant Signature:_________________________________ Date:______/______/_________

**By signing this, I am indicating that I have read and understand the language in the TERMS section of this application and agree to all.