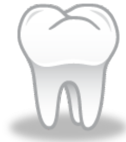
City of Gainesville Dental Insurance Change Form



1. Type of Change	2. Type of Plan	3. Type of Coverage
☐ Add / Delete Dependent ☐ Change Type of Coverage ☐ Terminate Coverage	☐ Choice ☐ Co Pay ☐ DHMO	☐ Individual ☐ Employee + Spouse ☐ Family ☐ Employee + 1 Child ☐ Employee + Children

4. Effective Date MM DD YYYY	5. Last Name First Name M.I.	6. Social Security Number

7. Reason for Change

☐ Marriage ☐ Open Enrollment ☐ Birth / Adoption ☐ Employment Status Change
☐ Divorce ☐ Overage Dependent ☐ Death ☐ Termination of Employment
☐ Return of Alternate Insurance ☐ Other ______________________________

8. Additions	First Name and Middle Initial Last Name (if different)	Social Security Number	Gender	Birth Date
Spouse			☐ M ☐ F	MM DD YYYY
Dependent Child			☐ M ☐ F	MM DD YYYY
Dependent Child			☐ M ☐ F	MM DD YYYY

9. Deletions	First Name and Middle Initial Last Name (if different)	Social Security Number	Gender	Birth Date
Spouse			☐ M ☐ F	MM DD YYYY
Dependent Child			☐ M ☐ F	MM DD YYYY
Dependent Child			☐ M ☐ F	MM DD YYYY

10. Acceptance of Coverage / Membership – By accepting this coverage, I acknowledge I have been informed of the current premiums for coverage and that said premiums may be adjusted at least annually and that Plan(s) design and Type of Coverage are subject to change. I also agree that the amount of any employee premiums not paid due to unpaid leave (of any kind), may be deducted from any and all monies due me (including return of pension contributions or monthly pension payments) if my employment is terminated, unless otherwise provided by the Family Medical Leave Act (FMLA).

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Signature of Applicant Date