The University of Georgia

Indemnity Dental Insurance
• *Change Form*•

I am:

- ☐ An active employee
- ☐ Retired
- ☐ On the COBRA plan

Clear this form

OFFICE USE ONLY

_____

APPLICANT'S NAME
Last First MI

Social Security Number

ACTIVE PAYROLL TYPE ☐ Academic ☐ Monthly ☐ Salaried ☐ Hourly

DAYTIME PHONE (Include area code)

Check coverage change you wish to make:

- ☐ Individual
- ☐ Individual + child
- ☐ Individual + spouse
- ☐ Family*
- ☐ Keep family, add a dependent*
- ☐ Keep family, remove a dependent

Remove (name)_____DOB_____

☐
☐

CHANGE EFFECTIVE DATE:_____

PAYROLL DEDUCTION AUTHORIZATION TO MY EMPLOYER (active employees only):

I hereby authorize you to make Elective Employer contributions by reducing my wages and salary by the required contributions for the coverage I have elected under the University System of Georgia Dental Plan and to remit this amount in payment of my contract. This authorization shall continue in effect during my employment or until revoked by me in writing.

I understand that I can change my election only during November to be effective the following January 1 except for approved changes in my family circumstances. I understand that any change I request because of family circumstances must be consistent with that circumstance and must be made within 31 days of the change in family circumstance(s)

_____ _____
Date signed *Signature required*

_____

REASON FOR CHANGE IN COVERAGE:

- ☐ Change in your employment status
- ☐ Change in your spouse's employment status
- ☐ Marriage
- ☐ Divorce
- ☐ Annual enrollment
- ☐ Birth/adoption of dependent
- ☐ Death of dependent
- ☐ Dependent no longer eligible
- ☐ Other_____

DATE CHANGE OCCURRED:_____

List all eligible individuals you wish to cover. Complete a dependent student application for children over age 19 (available from Employee Benefits). For eligibility information, refer to the dental plan booklet.

	Last name	First name	Relationship to you	Birthdate Month	Day	Year
1			☐ HUSBAND ☐ WIFE			
2			☐ DAU ☐ SON ☐ STEP			
3			☐ DAU ☐ SON ☐ STEP			
4			☐ DAU ☐ SON ☐ STEP			
5			☐ DAU ☐ SON ☐ STEP			
6			☐ DAU ☐ SON ☐ STEP			

Are you or your spouse covered under any other group/employer dental insurance program or Medicare?

☐ Yes ☐ No

✔ **If yes, complete sections A through C below.**

A. Name of insurance co. (s) & employer(s)

Self_____ Spouse/dependent_____

B. Effective date(s) of policy(ies) & contract numbers

C. Type of contract ☐ Self only ☐ Family

Revised 11/14/03