



Dental Insurance
• Change Form •

- I am:**
- An active employee
- Retired
- On the COBRA plan

OFFICE USE ONLY

APPLICANT'S NAME Last First MI	Social Security Number
ACTIVE PAYROLL TYPE <input type="checkbox"/> Academic <input type="checkbox"/> Monthly <input type="checkbox"/> Salaried <input type="checkbox"/> Hourly	DAYTIME PHONE (Include area code)

Check coverage change you wish to make:

Individual

Individual + child

Individual + spouse

Family*

Cancel Coverage

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 Augusta State University 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 open enrollment 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/SSN	First name	Relationship to you	Birthdate		
				Month	Day	Year
1			<input type="checkbox"/> HUSBAND <input type="checkbox"/> WIFE			
2			<input type="checkbox"/> DAU <input type="checkbox"/> SON <input type="checkbox"/> STEP			
3			<input type="checkbox"/> DAU <input type="checkbox"/> SON <input type="checkbox"/> STEP			
4			<input type="checkbox"/> DAU <input type="checkbox"/> SON <input type="checkbox"/> STEP			
5			<input type="checkbox"/> DAU <input type="checkbox"/> SON <input type="checkbox"/> STEP			
6			<input type="checkbox"/> DAU <input type="checkbox"/> SON <input type="checkbox"/> STEP			

Are you or your family currently covered under an ASU or any other group/employer dental insurance program or Medicare?

Yes No

✓ If yes, complete sections A through C below.

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

Self _____ Spouse/dependent _____

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

C. Type of contract Self only Family Other _____