DENTAL INSURANCE ENROLLMENT/CHANGE FORM

NEW ENROLLMENT:

Choose one: ☐ New Employee Coverage ☐ Open Enrollment ☐ Change in Status (See documentation information below)

Effective Date: ***(If Open Enrollment, effective date is January 1)***

TERMINATION:

Check all that apply: ☐ Terminate employee coverage ☐ Terminate spouse coverage ☐ Terminate child coverage

Effective Date***:*** ***(If Open Enrollment, effective date is December 31)***

Reason for RequestedTermination: (See documentation information below)

Required documentation: KCS dental insurance premiums are deducted from payroll before taxes. Therefore, IRS regulations require documentation of a change in status allowing enrollment or termination. Documentation must be provided with this form unless it is the open enrollment period or employee is within the first 31 days of their employment.

Employee Information:

First Name Middle Initial Last Name

Social Security # *(Social Security Number is required to process insurance cards)*

Sex ☐ Male ☐ Female Date of Birth Phone Number

Street or Mailing Address

City State Zip

Spouse Information (only required if enrolling or terminating coverage) :

First Name Middle Initial Last Name

Sex ☐ Male ☐ Female Date of Birth

Child Information (only required if enrolling or terminating coverage) :

First Name Middle Initial Last Name

Sex ☐ Male ☐ Female Date of Birth

First Name Middle Initial Last Name

Sex ☐ Male ☐ Female Date of Birth

First Name Middle Initial Last Name

Sex ☐ Male ☐ Female Date of Birth

First Name Middle Initial Last Name

Sex ☐ Male ☐ Female Date of Birth

Employee Signature_____ **Date**_____

DELTA DENTAL®
Delta Dental Plan of Tennessee

Return this form by mail or fax to:
Knox County Schools ▪ Employee Benefits
UT Tower, 5th Floor ▪ P.O. Box 2188 ▪ Knoxville, TN 37901-2188 Office
(865) 594-1686 ▪ Fax (865) 594-9523