

Jefferson County Board of Education

Direct Reimbursement Dental Enrollment Form

This is a:
 New Enrollment
 Change to Existing Enrollment

Coverage Elected:

Employee Employee + 1 Family Family/Couple Discount

Plan Elected:

Option I—Dental only Option II—Dental & Vision

Name of Employee _____

Location/School: _____

Social Security #: _____ - _____ - _____ Date of Birth: _____ - _____ - _____

Address: _____

_____ _____ _____

City State Zip

MUST Complete if you are electing dependent coverage.

Dependent Information (for additional dependents use the back of this form).

Spouse's Name _____

Social Security #: _____ - _____ - _____ Date of Birth: _____ - _____ - _____

Children's Name*	Date of Birth	Relationship to Employee	Social Security #
_____	____/____/____	_____	____-____-____
_____	____/____/____	_____	____-____-____
_____	____/____/____	_____	____-____-____
_____	____/____/____	_____	____-____-____

Your monthly deduction will be

Option I—Dental Only	Option II—Dental & Vision
Employee \$ 4.79	Employee \$10.44
Employee + 1 \$23.74	Employee + 1 \$34.14
Family \$46.48	Family \$62.58
Family/Both Full-Time Employees of JCBOE \$29.82	Family/Both Full-Time Employees of JCBOE \$45.92

I apply for the coverage that I have elected above. I am aware that:

1. Any premium required will be deducted from my paycheck on a pre-tax basis.
2. I am signing up for coverage until the next enrollment period and no changes can be made except in the case of a change in family status.

This information was explained to me prior to enrollment. By my signature below, I authorize any required payroll deduction and represent that all information shown on this form is correct.

Employee Signature: _____ **Date:** ____/____/____

Employee e-mail address: _____

* Dependent Children between the ages of 19 and 24 must be unmarried and full-time students, proof of full-time student status must be provided.

MUST Be Completed By Employer for Coverage To Be Effective

Date of Hire: ____/____/____ Effective Date of Coverage: ____/____/____

Employer Signature: _____ Late Applicant? Yes No

PLEASE RETURN THIS FORM ALONG WITH ENROLLMENT FORM

Any employee or dependents that are added to the Dental or Dental/Vision plan during the annual enrollment will have a reduction of benefits for the first year in the plan.

(50% reimbursement up to maximum of \$500 per person)

Employee Signature

Date