Dental Enrollment Form

Name of group (employer): Danville CCSD No. 118

Employee last name, first name, middle initial: (please print) _____

Social Security Number: _____

Address _____

Gender: ☐ male ☐ female Date of birth (month/date/year): _____

Effective Date of Coverage: _____

Type of coverage selected: Monthly Premiums (please check the appropriate box)

Low Plan ☐ employee only - $21.03
☐ employee + Spouse - $42.05
☐ Employee + Child(ren) $50.35
☐ Family - $ 77.08

High plan ☐ employee only - $29.55
☐ employee + Spouse - $59.10
☐ Employee + Child(ren) $76.67
☐ Family - $ 115.45

*** Dependent Relationship**: S=spouse, C=child, H=handicapped child, T=student

dependent last name	dependent first name	Social Security Number	gender	* Dependent Relationship	date of birth mm/dd/yyyy
				☐S ☐C ☐H ☐T	/ /
				☐S ☐C ☐H ☐T	/ /
				☐S ☐C ☐H ☐T	/ /
				☐S ☐C ☐H ☐T	/ /
				☐S ☐C ☐H ☐T	/ /
				☐S ☐C ☐H ☐T	/ /
				☐S ☐C ☐H ☐T	/ /

Employee Signature: _____