

Smithtown Central School District

Personnel/Human Resource Name: _____ **Group# 778**

DENTAL COVERAGE Effective: ____/____/____ Choose one: <input type="checkbox"/> Mandatory PPO <input type="checkbox"/> Voluntary PPO <input type="checkbox"/> Waive coverage	Choose one: <input type="checkbox"/> SINGLE <input type="checkbox"/> FAMILY <input type="checkbox"/> EMPL/SPOUSE <input type="checkbox"/> EMPL/DEPENDENT	Hire Date: ____/____/____ Occupation: _____
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NOTE: If you refuse Dental Benefits for yourself, you automatically refuse these benefits for any dependents.

SECTION 1 (Employee Information)

LAST NAME	FIRST NAME	MI	SEX	SOCIAL SECURITY NUMBER	DATE OF BIRTH
			M <input type="checkbox"/> F <input type="checkbox"/>	____/____/____	MONTH / DAY / YEAR
STREET ADDRESS				MARITAL STATUS	
				<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> OTHER _____	
CITY			STATE		ZIP CODE

SECTION 2 (Spouse Information)

NAME (LAST, FIRST, MI)	SEX	DATE OF BIRTH	SOCIAL SECURITY NUMBER
SPOUSE	M <input type="checkbox"/> F <input type="checkbox"/>		
OTHER INSURANCE <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, are the dependents listed below also covered through that plan) Explain: <input type="checkbox"/> Yes <input type="checkbox"/> No			

SECTION 3 (Dependent Information)-If your dependent is disabled -please include Dr.'s statement.

NAME (LAST, FIRST, MI)	SEX	DATE OF BIRTH	Student Status
DEPENDENT	M <input type="checkbox"/> F <input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No
DEPENDENT	M <input type="checkbox"/> F <input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No
DEPENDENT	M <input type="checkbox"/> F <input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No
DEPENDENT	M <input type="checkbox"/> F <input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No
DEPENDENT	M <input type="checkbox"/> F <input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No
DEPENDENT	M <input type="checkbox"/> F <input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No

Request to participate – I hereby request to participate in the insurance program and agree to contribute in the appropriate manner, if required.

" Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent act, which is a crime, and shall be subjected to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation."

The information provided above is true and correct to the best of my knowledge.

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