

LANSING COMMUNITY COLLEGE DENTAL ENROLLMENT FORM

Eligibility/Change/Termination Report

General Information - Employee

Name (Last) _____ (First) _____ (Middle) _____ Sex _____ Birth Date _____ Social Security # _____

Address (Street) _____ City _____ State _____ Zip Code _____ Telephone Number _____

Occupation _____ Hire Date _____ Effective Date _____

Section 2 – Dependent Information

Name (Last)	(First)	(Middle)	Sex	Date of Birth	Relationship	Effective Date

Is there a court order requiring coverage for any dependent in the case of divorced or legally separated parents? Yes No

Section 3 – Change/Correction

	Last Name	First Name	Social Security #	Effective Date
Employee: From:				
To:				
Dependents: From:				
To:				

A. Name Change

B. Termination of Benefits

Employee Effective Date of Termination: _____

Dependent Effective Date of Termination: _____

Spouse: _____

Dependent(s): _____

C. Additional Coverage - Will this enrollment result in coverage under more than one dental program for you or your spouse? Yes _____ No _____

Signature _____ Date _____