Decatur County Board of Education

Dental Reimbursement Plan Enrollment Election From

Employee Name: ______________________________

Employee SS#: ________/________/________ **Employee D/O/B:** ________/________/________

Address: ______________________________

City: ______________________ **State:** ____________ **Zip:** ____________

Home/Cell Phone: ______________________ **Work Phone:** ______________________

School/Work Location: ______________________ **E-Mail:** ______________________

Please choose the appropriate option below:

Employee/Single Coverage	**Family Coverage**	I choose to <u>NOT</u> enroll in the DCBOE Dental Reimbursement
$10.00 ☐	$30.00 ☐	☐

If you elected family coverage, please list dependents below:

Spouse: ______________________ **D/O/B:** ______/______/______ **SS#:** ______/______/______

Dependent: ______________________ **D/O/B:** ______/______/______ **SS#:** ______/______/______

Dependent: ______________________ **D/O/B:** ______/______/______ **SS#:** ______/______/______

Dependent: ______________________ **D/O/B:** ______/______/______ **SS#:** ______/______/______

Dependent: ______________________ **D/O/B:** ______/______/______ **SS#:** ______/______/______

Dependent: ______________________ **D/O/B:** ______/______/______ **SS#:** ______/______/______

HIPPA: This form is used to authorize, the DCBOE, and its agents, or employees, to use or disclose your protected Health Information (PHI) to the administrator, or employee's to administrate our DR Dental Plan. We will use your information for service, billing questions, claims, letters, and to provide your benefits to you. This authorization is at the request of the individual and will expire as of your termination of employment with the DCBOE. You have the right to revoke this authorization at any time by giving written notice of my revocation to the County Office. I understand that revocation of this authorization will not affect any action you took in reliance on this authorization before you received my written notice of revocation. I have had full opportunity to read and consider the contents of this authorization, and I understand that by signing this form, I am confirming my authorization of the use/or disclosure of my protected health information as described in this form.

Do you have other Dental Insurance? Yes ☐ No ☐

If yes, name of other company: ______________________________

Address: ______________________________

City: ______________________ State: ____________ Zip: ____________

Policy Number: ______________________________

I elect or decline coverage offered to me by the DCBOE Dental DR Plan as marked above during open enrollment. I hereby authorize my employer, until this authorization is revoked by written notice, to deduct each month from any earned or accrued wages due me, the amount applicable to the coverage I have selected. I hereby certify that the above information and any attachments thereto are true and correct. I understand misrepresentation or falsification will subject me to penalties and possible legal action.

Employee Signature: ______________________ **Date:** ________/________/________

ED 07/09