## **City of Titusville Dental Benefit Plan**



PO BOX 916188, LONGWOOD, FL 32791-6188

Employee Name:  Mailing Address:  Address  Address:  Bendoyre Only Gender:  Social Security #:  Social	Enr	ollme	nt Application	Effective D	ate:				Group: 39
Mailing Address   City   St. Zip Code   Phom Date of Full-Time Employment:   Date of Birth:   Gender:   M / Title:   E-Mail Address:   Social Security #:	Emp	loyee N	lame:				Member I	D #:	aime Administrate
Address City St. Zip Code Phon Date of Full-Time Employment: Date of Birth: Gender: M / Title: E-Mail Address: Social Security #: Social Security #: Social Security #: Social Security #:	Mail	ina Ado	dress:		_		,	,	
Title:			Address						
Change Application   Effective Date:	Date	of Full	-Time Employment: _		Dat	e of Birth	:	_ Gender:	: [_] <b>M /</b> [_] I
Dental Coverage (Reason:	Title	:	E-Mail Ac	ldress:			Social Secu	rity #:	
Employee Only	Dent	al Plan	Enrollment:		(	SSN WIII be u	ised for federal repo	rting & identifica	ation purposes on
Change Application	☐ Eı	mployee	Only Employee						
Change Application	COI	MPLETE	DEPENDENT INFORMA	TION ONLY IF	OU WA	NT FAMILY	COVERAGE *LI	ST LEGAL DEF	PENDENTS ONL
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Name Change:   New Street Address Change:   New Street Address   City   State   Zip									
Address Change: New Street Address New Street Address Reason for Dental Coverage Change: Employee Only Employee & Spouse Employee & Child(ren) Employee & Family Cancel Dental Coverage Exhaustion of COBRA benefits (date: )  COMPLETE ONLY IF YOU WANT TO ADD / DELETE FAMILY MEMBERS LIST LEGAL DEPENDENTS ONL Add Delete Full Name of Dependent Date of Birth Gender Relationship to Employee SSN (if adding  e any other Group Dental Plan coverage in force? NO (If No, Skip A. through C.) Eff. Date: Single Coverage or Family Cowerage SSN (if adding Eff. Date: Single Coverage or Family State St	Emp	loyee N	Name:		Member ID #:				
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Employee & Child(ren) Employee & Family Loss of dental coverage due to eligibility (date:) Cancel Dental Coverage Exhaustion of COBRA benefits (date:) Other (Explain)  COMPLETE ONLY IF YOU WANT TO ADD / DELETE FAMILY MEMBERS *LIST LEGAL DEPENDENTS ONL Add Delete Full Name of Dependent Date of Birth Gender Relationship to Employee SSN (if adding  e any other Group Dental Plan coverage in force?NO (If No, Skip A. through C.)YES (If Yes, Complete A. Through C.)YES					_	-		•	
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