



**AETNA DENTAL
ENROLLMENT/CHANGE REQUEST**

NEW HIRE DATE: / /
 CHANGE / /

CHECK PLAN TYPE

- Plan A PPO Plan
- Plan B Alternate Plan (FOC Comp)
- Plan B DMO Plan (FOC DMO)
- Plan C

CHECK COVERAGE

- Employee
- Employee/Spouse
- Employee/Child(ren)
- Family

Employer Information

Employer Name - Full Name of Business or Organization
Consolidated Schools-Brandywine School District

Employer Address (Street, City, State, ZIP Code)
1000 Pennsylvania Ave Claymont DE 19703

Employee Information - Please Print All Information

Employee Social Security Number: _____ Employee Name (Last, First, Middle Initial): _____ Employee Home Address: _____

Date of Birth: _____ Home Telephone Number: _____ () _____ Work Location: _____ City: _____ State: _____ ZIP Code: _____

Individuals Covered (List individuals for whom you are electing/changing coverage.) Check this box if you are refusing coverage for your dependents.

| Add or Remove | NAME (First/Middle Initial/Last) | Social Security | Birthdate MM/DD/YY | Sp for spouse D for daughter S for son | Prior Insur. Plan | Other Dental Coverage | Hazard- (capped) | Student Age 19 or older | DMO PRIMARY CARE DENTIST | | Prev. Seen |
|---------------|----------------------------------|-----------------|--------------------|--|-------------------------------|-------------------------------|-------------------------------|-------------------------------|--------------------------|------|------------------------------|
| | | | | | | | | | ID # | Name | |
| | | - - - | / / | | Yes* <input type="checkbox"/> | Yes* <input type="checkbox"/> | Yes* <input type="checkbox"/> | Yes* <input type="checkbox"/> | ID # | Name | Yes <input type="checkbox"/> |
| | | - - - | / / | | Yes* <input type="checkbox"/> | Yes* <input type="checkbox"/> | N/A <input type="checkbox"/> | N/A <input type="checkbox"/> | ID # | Name | Yes <input type="checkbox"/> |
| | | - - - | / / | | Yes* <input type="checkbox"/> | Yes* <input type="checkbox"/> | Yes* <input type="checkbox"/> | Yes* <input type="checkbox"/> | ID # | Name | Yes <input type="checkbox"/> |
| | | - - - | / / | | Yes* <input type="checkbox"/> | Yes* <input type="checkbox"/> | Yes* <input type="checkbox"/> | Yes* <input type="checkbox"/> | ID # | Name | Yes <input type="checkbox"/> |
| | | - - - | / / | | Yes* <input type="checkbox"/> | Yes* <input type="checkbox"/> | Yes* <input type="checkbox"/> | Yes* <input type="checkbox"/> | ID # | Name | Yes <input type="checkbox"/> |
| | | - - - | / / | | Yes* <input type="checkbox"/> | Yes* <input type="checkbox"/> | Yes* <input type="checkbox"/> | Yes* <input type="checkbox"/> | ID # | Name | Yes <input type="checkbox"/> |

EMPLOYEE SIGNATURE _____

DATE _____