Aetna AETNA DENTAL ENROLLMENT/CHANGE REQUEST

| | NEW
| | CHANGE

HIRE DATE: / /

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 Christina School District

Employer Address (Street, City, State, ZIP Code)
600 Lombard Street, Wilmington DE 19801

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 Yes*	Other Dental Coverage Yes*	Handi-capped Yes*	Student Age 19 or older Yes*	DMO PRIMARY CARE DENTIST ID# & NAME	Prev. Seen Yes
		- -	/ /		☐	☐	N/A	N/A	ID # Name	☐
		- -	/ /		☐	☐	☐	☐	ID # Name	☐
		- -	/ /		☐	☐	☐	☐	ID # Name	☐
		- -	/ /		☐	☐	☐	☐	ID # Name	☐
		- -	/ /		☐	☐	☐	☐	ID # Name	☐
		- -	/ /		☐	☐	☐	☐	ID # Name	☐

EMPLOYEE SIGNATURE DATE