DENTAL AND VISION ENROLLMENT AND CHANGE FORM

To make changes or enroll for the first time, complete the following and submit it to your HR by the open enrollment deadline. You do not need to complete a form to maintain current coverage.

MEMBER

Last Name | First Name | MI | State of Ohio User ID | County

Street Address | City | State | ZIP Code

Worksite | Office Telephone Number | Date of Birth

DENTAL

	Single	Family
☐ Delta Dental	☐	☐
☐ Waive Dental coverage		

VISION — CHOOSE ONE

	Single	Family
☐ VSP	☐	☐
☐ EyeMed	☐	☐
☐ Waive Vision coverage		

DEPENDENTS

Updating dependent information? List your spouse first, then your eligible dependent children. Attach a separate sheet if necessary. For relationship, use SP for Spouse, C for Child, S for Stepchild, G for Legal Guardian, F for Foster Child, or QMCSO for a Qualified Medical Child Support Order.

First Name	Last Name *(if different from yours)*	SSN	Birthdate	Sex	Relation	Add to		Drop from	
						D	V	D	V
						D	V	D	V
						D	V	D	V
						D	V	D	V

ALL DEPENDENTS REQUIRE DOCUMENTATION OF ELIGIBILITY. Dependents ages 19-23 require students status verification. A listing of required documentation can be found at **das.ohio.gov/eligibilityrequirements.**

I certify the above information to be accurate and that my dependents and I are eligible for benefits. I verify that all dependents meet eligibility criteria.

Member Signature | Date

HR: Please complete the information immediately below, and verify the information above before enrolling employee or making changes.

Employee Appointment Date | CBU | Agency | Effective Date

Signature of Agency Designee | Date | Designee Phone Number

You are responsible for verifying eligible dependents and providing the effective date.

4/18

UNION BENEFITS TRUST