DENTAL Insurance Benefit Feb. 2018 - Jan. 2019

Anthem
BlueCross BlueShield
Dental Enrollment

☐ **YES**, I want to participate on a pre-tax basis for DENTAL insurance premiums and I will complete the application below.

☐ **NO,** I do NOT want to participate in my employer's DENTAL insurance plan.

If you elect to have deductions made from your paycheck, you may elect to have those deductions made "pre-tax", which will reduce your federal, state and social security taxes. The only drawback to this plan is that your earnings reported to social security will be less, and when you retire, your social security benefits may be affected by your earnings record. Everyone chooses this Salary Reduction Plan. (Place a check here _____ if you do NOT want to participate in the Salary Reduction Plan for premiums deducted from your paycheck.)

I authorize my employer to make the following salary deductions:

PART A – ENROLLMENT INFORMATION

Select Coverage Check ONE BOX Only	Coverage TYPE:	MONTHLY Deduction
	☐ *Employee ONLY*	$ 27.27
	☐ *Employee and CHILD/CHILDREN*	$ 65.72
	☐ *Employee and SPOUSE*	$ 55.64
	☐ *Employee and FAMILY*	$ 97.46

PART B – EMPLOYEE INFORMATION

Employee's NAME:	*LAST*	*FIRST*	*Middle Initial*	*Social Security NUMBER* / /
GENDER: ☐ *Male* ☐ *Female*	*MARITAL STATUS:* *Single* ☐ *Married* ☐ *Widowed* ☐ *Divorced* ☐ *Legally Separated* ☐			*Date of BIRTH (Month-Day-Year)* / /
Employee's ADDRESS:	*ADDRESS*		*STATE*	*ZIP CODE*
Home PHONE ( )	**Work/Cell PHONE** ( )	**EMAIL Address**		

PART C – DEPENDENT INFORMATION

RELATIONSHIP to Employee:	NAME: First, Middle & Last NAME (include last name only if different)	GENDER:	DATE of BIRTH: Month/Day/Year	Full Time Student?	Unmarried?
SPOUSE		M ☐ F ☐	/ /	Yes ☐ No ☐	Yes ☐ No ☐
Dependent CHILD		M ☐ F ☐	/ /	Yes ☐ No ☐	Yes ☐ No ☐
Dependent CHILD		M ☐ F ☐	/ /	Yes ☐ No ☐	Yes ☐ No ☐
Dependent CHILD		M ☐ F ☐	/ /	Yes ☐ No ☐	Yes ☐ No ☐
Dependent CHILD		M ☐ F ☐	/ /	Yes ☐ No ☐	Yes ☐ No ☐

PART D – EMPLOYEE SIGNATURE

Do you have other dental coverage? Yes ☐ No ☐ Name of Carrier:	Policy/ID Number:	
Do your dependents have other dental coverage? Yes ☐ No ☐ Name of Carrier:	Policy/ID Number:	
I am enrolling myself and/or my dependents and authorize payroll deductions. I have read, or have had read to me, the completed application and I realize that any false statement or misrepresentation in the application may result in a loss of coverage under the policy.	EMPLOYEE SIGNATURE:	DATE:

RETURN COMPLETED FORM TO: Waco, Inc. Attention: Bonnie Ballsrud
P.O. Box 829 Sandston, VA 23150

Any questions? Contact: bballsrud@wacoinc.net phone: (804) 226-3206/ fax (804) 226-3218