Dental and Vision Care Election Document

Please complete this document to elect or waive your Dental and Vision Care coverage. Once completed, print this document for your records and submission.

1. Employee Information

Full Name:

Employee ID / National ID:

Date of Birth (MM/DD/YYYY):

Email Address:

2. Dental Care Benefit Election

Enrollment Decision (Enter "ENROLL" or "WAIVE"):

Selected Dental Plan (e.g., Basic Dental, Premium Dental):

Dental Coverage Level (e.g., Employee Only, Employee + Spouse, Family):

3. Vision Care Benefit Election

Enrollment Decision (Enter "ENROLL" or "WAIVE"):

Selected Vision Plan (e.g., Standard Vision, High-Option Vision):

Vision Coverage Level (e.g., Employee Only, Employee + Spouse, Family):

4. Dependent Coverage Details (If Applicable)

Please list any dependents to be covered under the elected plans.

Dependent 1:

Name:

Relationship:

Date of Birth (MM/DD/YYYY):

Dependent 2:

Name:

Relationship:

Date of Birth (MM/DD/YYYY):

5. Authorization and Signature

By signing below, I authorize the payroll deductions associated with the elections made on this document. I understand these elections cannot be changed until the next open enrollment period unless I experience a qualifying life event.

Authorized Signature (Type Full Name):

Date (MM/DD/YYYY):