Dental and Vision Benefits Enrollment Form

Group Name: Nassau County School Board

Please complete the following information					
Social Security No.	Last Name	First	MI	Date of Birth	
Home Address		Home Phone ( )		Gender M ☐ F ☐	
City	State	Zip Code	Business Phone ( )	Dental Facility # (HS205 only)	

List All Your Eligible Dependents to be Covered					
First MI Last	Enrollment Choice	Social Security No.	Dental Facility # HS205 only	Gender	Date of Birth
Spouse	☐ Dental ☐ Vision			M F	
Child	☐ Dental ☐ Vision			M F	
Child	☐ Dental ☐ Vision			M F	
Child	☐ Dental ☐ Vision			M F	
Child	☐ Dental ☐ Vision			M F	
Effective Date 10/01/2020	E-mail Address			Date of Hire	

Please Check your Dental and Vision Enrollment Choice Monthly Premiums				
Plan Name	☐ Dental HS205	☐ Dental Advantage	☐ Dental PPO	☐ Vision HV130
Employee Only	☐ $17.98	☐ $26.30	☐ $34.16	☐ $ 6.84
Employee + One Dependent	☐ $35.58	☐ $49.82	☐ $64.70	N/A
Employee + Spouse	N/A	N/A	N/A	☐ $13.66
Employee + Child(ren)	N/A	N/A	N/A	☐ $17.08
Employee + Family	☐ $63.54	☐ $82.02	☐ $106.52	☐ $23.90

I wish to enroll in the plan indicated above as offered through my employer. I understand that this is a minimum one (1) year contract. I hereby authorize my employer to deduct all applicable contributions from my salary or other compensation for the plan year, and for future renewal period(s). I understand that such contribution rate is subject to change on the anniversary date of the plan. I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge.

Signature: ______________________________ Date: ________________