DENTAL TRANSACTION FORM

Orange County Self-Insured

*****OPTION TRANSFER 2012*****

Last Name	First Name	MI

Street Address	Social Security Number
City / State / Zip Code	Date of Birth
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced	Date of Marriage
☐ Decline Coverage	Date of Hire
☐ Request Enrollment – Individual ☐ Request Enrollment – Family	Complete Dependent Information

☐ Change Name – Previous Name Was:	
☐ Change To Individual - Reason:	Date:
☐ Change To Family - Reason:	Date:
☐ Add a dependent - Reason:	Date:
☐ Remove a dependent - Reason:	Date:

List Name of Dependent(s) to be Added or Removed

Last Name	First Name	Date of Birth	Relationship	Social Security No.

Note: Relationship: Sp-Spouse, Dtr-Daughter, Son-Son, S/Son-Stepson, S/Dtr-Stepdaughter, L/G-Legal Guardianship

Is your spouse employed by Orange County OR Orange County Community College YES _____ NO_____

YOU MUST PROVIDE PROOF for all dependents being added to your coverage for the first time: copy of government issued marriage certificate if adding spouse, birth certificate(s), social security card(s), legal guardianship papers, etc. **. Plan covers dependents up to age 19. Dependents 19-25 years old must be full-time students. Full-time student verification must be sent each semester to Fitzharris Administrators.**

I understand that if I am required to make contributions as a result of this request, my employee contributions for the benefit will be taken on a pre-tax basis (IRS Section 125) unless I notify Risk Management, in writing, to the contrary.

SIGNATURE: _____ **DATE:** _____

For Risk Use Only:

Group No.	Dept No.	Effective Date	Documents on File	