



ORANGE COUNTY SELF-FUNDED DENTAL / VISION ENROLLMENT FORM

COVERAGE	INDIVIDUAL	FAMILY	NONE
DENTAL			
VISION			

LAST NAME	FIRST NAME	SOCIAL SECURITY NUMBER
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ADDRESS _____

DATE OF BIRTH	DATE OF HIRE
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Dependent Information

Last Name (If Different)	First Name	Date of Birth	Relationship	Social Security No

Risk Management Division / Health Benefits Unit - 291-2139

Reminder: Student Certification MUST be on file for each dependent listed above who is between the ages of 19 and 25

EMPLOYEE SIGNATURE: _____ **DATE:** _____

For Risk Use Only: Effective Date: _____

Group Number: _____

Payroll Of: _____

Comments: _____