



DENTAL Insurance Benefit Feb. 2021 - Jan. 2022

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

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

Dental Enrollment

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	<u>Coverage TYPE:</u>	<u>MONTHLY Deduction</u>
	<input type="checkbox"/> <i>Employee ONLY</i>	\$ 22.09
	<input type="checkbox"/> <i>Employee and CHILD/CHILDREN</i>	\$ 53.23
	<input type="checkbox"/> <i>Employee and SPOUSE</i>	\$ 45.06
	<input type="checkbox"/> <i>Employee and FAMILY</i>	\$ 78.94

PART B – EMPLOYEE INFORMATION

Employee's NAME:	<i>LAST</i>	<i>FIRST</i>	<i>Middle Initial</i>	<i>Social Security NUMBER</i> / /
GENDER: <input type="checkbox"/> <i>Male</i> <input type="checkbox"/> <i>Female</i>	MARITAL STATUS: <input type="checkbox"/> <i>Single</i> <input type="checkbox"/> <i>Married</i> <input type="checkbox"/> <i>Widowed</i> <input type="checkbox"/> <i>Divorced</i> <input type="checkbox"/> <i>Legally Separated</i>			<i>Date of BIRTH (Month-Day-Year)</i> / /
Employee's ADDRESS:	<i>ADDRESS</i>		<i>CITY, STATE</i>	<i>ZIP CODE</i>
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?	
		M	F		Yes	No	Yes	No
SPOUSE		<input type="checkbox"/>	<input type="checkbox"/>	/ /	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dependent CHILD		<input type="checkbox"/>	<input type="checkbox"/>	/ /	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dependent CHILD		<input type="checkbox"/>	<input type="checkbox"/>	/ /	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dependent CHILD		<input type="checkbox"/>	<input type="checkbox"/>	/ /	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dependent CHILD		<input type="checkbox"/>	<input type="checkbox"/>	/ /	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PART D – EMPLOYEE SIGNATURE

Do you have other dental coverage? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Name of Carrier:		Policy/ID Number:
Do your dependents have other dental coverage? Yes <input type="checkbox"/> No <input type="checkbox"/>		
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, Benefits

P.O. Box 829 Sandston, VA 23150

Any questions? Contact:

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