Dental Enrollment Form

Part 1: Employee Information:

Union Code: (Office Use Only)	

Social Security #:		Department:	
Last Name:		Home Address:	
First Name:	M.I.	City: State:	Zip:
Date of Hire:		Date of Birth:	Male____Female____
Effective Date:		Marital Status:	

Part 2: Plan Selection: The "cost" amounts listed below are deducted each pay period.

Employees adding dependents and /or selecting an upgraded plan contribute Ch. 78 in addition to the amounts shown.

Delta Dental		
Plan	**Tier**	**Cost**
Premier 50/50	☐ Single	Ch. 78
Preferred 80/20 3238-6003, 6004	☐ Single ☐ Family	$4.10 $31.78
Fixed Co-Pay 3238-6401, 6402	☐ Single ☐ Employee + 1 ☐ Employee + 2 or more	$6.77 $20.42 $40.01
Premier 80/20 3238-0006,0008	☐ Single ☐ Family	$7.47 $43.25
Enhanced Premier 3238-0012, 0013	☐ Single ☐ Family	$11.19 $55.95

Dental Services Organization (DSO)		
Plan	**Tier**	**Cost**
Eastern Dental Management 85A253, 85A254	☐ Single ☐ Employee + 1 ☐ Employee + 2 or more	$6.80 $20.27 $39.87
Provide your dental center location and site ID number selection from the list of participating Dental Centers provided by DSO/Eastern Dental. Dental Center: _____ Site ID Number: _____		

Delta Dental (Officer Plans)		
Plan	**Tier**	**Cost**
County Police Officer 1296-0002	☐ Composite	$14.82
Correction Officer 1296-0004	☐ Composite	$19.35
Sheriff Officer 1296-0005	☐ Composite	$23.79

Part 3: Dependent Information: Each child must be **under the age of 23**.

Relation	Change Type	Dependent Name (Last Name, First Name MI)	Gender	Date of Birth	Social Security #
Spouse	☐ Add ☐ Remove		☐ Male ☐ Female	___/___/___	
Child	☐ Add ☐ Remove		☐ Male ☐ Female	___/___/___	
Child	☐ Add ☐ Remove		☐ Male ☐ Female	___/___/___	
Child	☐ Add ☐ Remove		☐ Male ☐ Female	___/___/___	
Child	☐ Add ☐ Remove		☐ Male ☐ Female	___/___/___	

Part 4: Enrollment/Change Reason:

Type of Event: ☐ Marriage ☐ Birth ☐ Divorce ☐ Open Enrollment ☐ New Hire ☐ Other: _____

Date of Event: _____

_____ EMPLOYEE SIGNATURE

_____ DATE

Updated: November 2026