



- Reason
- Open Enrollment
 - Qualifying Event
 - New Employee Election

Effective Date: _____

A. Employee Information					
Name (Last)	(First)	(MI)	PCC ID#	Home Phone	Work Phone
Street Address (No P.O. Boxes)			City, State, Zip		Mailing Address (if different)

B. Dental Coverage Information		
Type of Dental Plan Selected:		Individuals Covered:
<input type="checkbox"/> EDS - DMO Coverage Group #15357	<input type="checkbox"/> United Concordia - PPO/Indemnity Group #845160 000	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependents

List all Changes for Dental Coverage (Plan Selection or Dependent Additions/Deletions)								
Relationship	Last Name	First Name	MI	Sex	SSN	Birthdate	Fulltime Student?	(A)dd or (D)elete
Self								
Spouse								
Dependent								
Dependent								
Dependent								

NOTES:
 1. List **all dependents as appropriate**. Use multiple forms if needed.
 2. If you elect the EDS - DMO Dental coverage, contact EDS customer service or visit www.mydentalplan.com to select your Primary Care Dentist.

I represent that all information supplied in this application is true and correct. Any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act which is a crime. I authorize deductions from my earnings at the required contributions towards the cost of the coverage. I authorize any dentist or other dental care provider to furnish any representative of Employers Dental Services or United Concordia, as appropriate, any and all records pertaining to dental history, services, or treatment of anyone enrolled for purposes of review, investigation, or evaluation of an application or claim. This authorization shall remain valid for so long as my coverage remains in force. My authorized representative or myself are entitled to receive a copy of the authorizations form.

I affirm that all of the dependents listed are qualified to be covered by Pima Community College (PCC) benefits as defined in the *Personnel Policy Statement for College Employees*. I acknowledge that children on their 19th birthday are eligible to be covered under PCC benefits with deductions for coverage made post-tax unless they are a full-time student; and, that it is my responsibility to notify the College's Benefits office when a dependent is no longer a full-time student. I further acknowledge that children upon their 25th birthday are ineligible for coverage under PCC benefits regardless of their student status.

Signature Date