

**OPEN ENROLLMENT**  
**October 12, 2009 through October 30, 2009**

**Benefits Service Center**  
 Post Office Box 2115  
 602 Scarboro Road, MS-8258  
 Oak Ridge, Tennessee 37831-2115  
 Local 865-574-1500  
 Toll-free 1-877-861-2255  
 Fax 865-241-0531



**Dental**  
**ENROLL, ADD, CHANGE, OR CANCEL FORM**

INSURED'S NAME (First) (Middle Initial) (Last Name)		SOCIAL SECURITY NO.		BADGE
STREET		CITY	STATE	ZIP CODE
EMPLOYER (NAME OF COMPANY)		PAYROLL <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly		EFFECTIVE DATE
STATUS	<input type="checkbox"/> ACTIVE <input type="checkbox"/> RETIRED <input type="checkbox"/> LONG TERM DISABILITY <input type="checkbox"/> DISPLACED DEFENSE WORKER		<input type="checkbox"/> SPOUSE OF A RETIREE <input type="checkbox"/> SPOUSE OF A DECEASED RETIREE <input type="checkbox"/> 3-MONTH CONTINUATION <input type="checkbox"/> SPOUSE OF A DECEASED EMPLOYEE <input type="checkbox"/> COBRA	
	IF RETIRED, DO YOU HAVE 10 YEARS OF FULL-TIME COMPANY SERVICE? <input type="checkbox"/> YES <input type="checkbox"/> NO	COMPANY SERVICE DATE	IF THE INSURED IS A SPOUSE OF A RETIREE THAT IS OVER AGE 65, LIST RETIREE'S SOCIAL SECURITY NO.	
COVERAGE TYPE <input type="checkbox"/> METROPOLITAN LIFE <input type="checkbox"/> DELTA DENTAL		COVERAGE LEVEL <input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> DUAL <input type="checkbox"/> FAMILY		
<b>EMPLOYEES</b> I ELECT TO HAVE THIS DEDUCTION MADE ON A BEFORE-TAX BASIS FROM MY WAGES. <input type="checkbox"/> YES <input type="checkbox"/> NO		<b>RETIREES</b> I AUTHORIZE THIS DEDUCTION TO BE TAKEN FROM MY PENSION PAYMENT. <input type="checkbox"/> YES <input type="checkbox"/> NO		<b>LONG TERM DISABILITY PARTICIPANTS</b> I AUTHORIZE THIS DEDUCTION TO BE TAKEN FROM MY DISABILITY PAYMENT. <input type="checkbox"/> YES <input type="checkbox"/> NO

**INSTRUCTIONS**

Complete this worksheet to enroll, add, or cancel a dependent from your dental insurance, or make changes to your dependents' personal information (such as name spelling or date of birth). If you are adding or canceling coverage on a dependent, you must indicate a reason in the area below the grid.

**PLEASE NOTE** -Changes to your dental insurance cannot take effect until you return this enrollment form to: **Benefits Service Center**, P.O. Box 2115, 602 Scarboro Road, MS-8258, Oak Ridge, TN 37831-2115

**DENTAL INSURANCE ENROLLMENT INFORMATION**

First Name	Last Name	Date Of Birth	Sex	Relationship Spouse, Son, Daughter, or Handicapped Child Over Age 24	Enroll, Add, Change or Cancel Coverage
				Self	

**REASON FOR ADDING OR CANCELING COVERAGE** *I understand that any additions to the dental plan must be added within 30 days of the qualifying event. If it is more than 30 days, the addition can only be made during an open enrollment. I can cancel coverage at any time, however, if there is not a qualifying event or it is more than 30 days since the qualifying event, I understand that if the premium is deducted from my pay on a pre-tax basis, the deduction will not be changed or cancelled until the next calendar year.*

REASON FOR CHANGE	<input type="checkbox"/> MARRIAGE	DATE OF MARRIAGE	<input type="checkbox"/> BIRTH OR ADOPTION	(A copy of the adoption papers signed by the court must be provided.)	DATE OF BIRTH OR ADOPTION
	<input type="checkbox"/> DIVORCE	(A copy of the divorce decree signed by the court official must be provided.)	DATE OF DIVORCE	<input type="checkbox"/> DEPENDENT LOST ELIGIBILITY STATUS	DATE OF EVENT
	<input type="checkbox"/> CHANGE OF EMPLOYMENT STATUS (SELF OR SPOUSE)	DATE OF EVENT	<input type="checkbox"/> OTHER EXPLAIN BELOW		DATE OF EVENT
	OTHER CHANGE EXPLANATION				

SIGNED	DATE
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