

2022/23 Annual Open Enrollment Change Form

Dental Only Retirees

This form is due by Wednesday, August 31, 2022 ONLY IF CHANGES ARE BEING MADE

General Information

Last Name	First Name	MI
<input type="text"/>	<input type="text"/>	<input type="text"/>
Social Security Number	Date of Birth (MM/DD/YYYY)	Gender
<input type="text"/>	<input type="text"/>	<input type="text"/> M <input type="text"/> F
Daytime Phone	Evening Phone	
<input type="text"/>	<input type="text"/>	
Street Address	Apt/Suite/PO Box Number	
<input type="text"/>	<input type="text"/>	
City	State	Zip Code
<input type="text"/>	<input type="text"/>	<input type="text"/>
		Date of Retirement (MM/DD/YYYY)
		<input type="text"/>

Dental – Please elect your changes below

Coverage Type Cigna DHMO Cigna DPPO No Coverage

DHMO Office # _____

Coverage Level Retiree Only Retiree +1 Family

Dependent Information

Please enter information for each dependent you wish to enroll for coverage. You must provide proof of dependency and the social security number of each dependent. Dependents will not be enrolled if this information is missing.

1. Dependent Information

Last Name	First Name	MI
<input type="text"/>	<input type="text"/>	<input type="text"/>
Social Security Number	Date of Birth (MMDDYYYY)	Relationship:
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
Gender		_____
<input type="checkbox"/> Female <input type="checkbox"/> Male		
DHMO Office Number (DHMO plan only)		Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No

2. Dependent Information

Last Name	First Name	MI
<input type="text"/>	<input type="text"/>	<input type="text"/>
Social Security Number	Date of Birth (MMDDYYYY)	Relationship
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other
Gender		_____
<input type="checkbox"/> Female <input type="checkbox"/> Male		
DHMO Office Number (DHMO plan only)		Current Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No

