Dental & Vision Benefits Application

Employee Information

First Name

Last Name

Employee ID

Date of Birth

Email

Phone

Address

Benefits Selection

☐ Enroll in Dental Plan ☐ Enroll in Vision Plan

Coverage Type

Select Coverage

Dependent Information (if applicable)

Name

Date of Birth

Relationship

Name

Date of Birth

Relationship

Authorization

☐ I hereby certify that the above information is true and correct to the best of my knowledge.

Signature

Date
