Enrollment Form – Columbia Dental Plan for Retired Officers

Please complete this enrollment form and mail to:

EBPA CL #18
PO Box 1387
Williston, VT 05495-1387

If you elect auto payment with EBPA your bank statement will have the description "DFS In. FLEX Plan." Funds will occur on the first business day of each month.

I wish to enroll:

[ ] myself only ($15)

[ ] myself and one dependent ($30)

[ ] myself and more than one dependent ($45)

Retiree Information

I elect the Dental Plan for Retired Officers, effective: _____			
Last Name:		**First Name:**	
Social Security Number:	– –	**Date of Birth:**	– –
Mailing Address:			
Telephone Number:	– –	**Retirement Date:**	– –

Dependent Information

Only the spouse who was your dependent when you retired will be eligible for dental benefits after you retire. However, you may continue to add new dependent children to your coverage. Eligible children are those who are under age 19, or if a full-time student, under age 26.

Enter information for all dependents to be covered. You must provide proof of each dependent's eligibility if you are selected for an audit.

Dependent #1: Name:				
Social Security Number:	– –	**Relationship:**	**Date of Birth:**	– –
Dependent #2: Name:				
Social Security Number:	– –	**Relationship:**	**Date of Birth:**	– –
Dependent #3: Name:				
Social Security Number:	– –	**Relationship:**	**Date of Birth:**	– –

Annual re-enrollment is required for the dental plan. If a retired employee does not re-enroll each year, he/she will permanently forfeit eligibility for dental benefits.

I understand that if I waive my Columbia University Retiree Dental Coverage at this time, future eligibility will be determined upon the terms of the retiree dental plan in effect at the time.

Retiree Signature: _____	***Date (mm/dd/yyyy):***