Northern School District Trust

Telephone: 715-682-2363 Ext 133
Fax : 715-682-7244

NSDT
C/O CESA #12
618 Beaser Avenue
Ashland, WI 54806

DENTAL ENROLLMENT

Employee

Last Name _______________ First _______ M.I. _______ Date of Birth _______ Social Seciurity # _______

Address _______________ Home Phone # _______________

City _______ State _______ Zip _______ Sex ____M ____F

Marital Status: ____Single ____Married

Coverage

___ Single ___Family ___Other _______________

Spouse/ Dependent

Spouse: Last Name _______________ First _______________ M.I. ______
Date of Birth _______________ Employer _______________

Dependents:

First Name	M.I.	Last (If Different than Employee)	Date of Birth	Sex (M or F)

Are any dependent children over 18? Y N If Yes, do they attend school full-time?__Y____N
If Yes, where? _______________ Do you provide more than 50% of the economic support of the dependents listed above? Y N
Did you claim all of the dependents listed above on your last income tax return? Y N

Other

Do you, your spouse, or any of your dependents have any other Dental coverage? ____Y ___N
If Yes, Name of Company _______________ Policy # _______________

Refuse

I have decided not to apply for the Dental Coverage Offered for:___Self____Dependents____Other and I understand that evidence of insurability may be requested if I desire to apply for such coverage at a later date.

Signature _______________ **Date** _______________

Accept

I enroll for the eligible benefits I indicated in the coverage section and authorize deductions from my earnings if required.

Signature _______________ **Date** _______________

Employer Complete: **District** _______________ **Group #** ___________
Position of Applicant: _______________
Effective Date of Coverage: