ENROLMENT FORM FOR GEHI DENTAL PLAN

This section to be completed by employee

Full Name _____

Address _____

_____

Department _____ Sex Male ☐ Female ☐

Date of Birth dd/mm/yr / / /

List below names of Dependents to be covered. Spouses, unmarried children under 16 yrs plus students ages 16-21 are eligible to be enrolled if they are covered under the GEHI Health Plan.

Name	Relationship	Date of Birth

DENTAL COVERAGE SECTION

Please tick the applicable level of dental insurance coverage you wish implemented.

Basic Dental ☐

Comprehensive Dental ☐

I hereby authorize the necessary payroll deduction to be made from my salary.

Signature of Employee _____ Date _____

This section to be completed by Employer (Please print)

Date employee enrolled in Dental Plan dd/mm/yr / / /

Employee Social Insurance Number _____

Department _____

Signed on behalf of Employer _____ Date / / /