OSSEO AREA SCHOOLS
ISD 279

Dental Open Enrollment

SECTION 1 – EMPLOYEE INFORMATION (Please complete in full and print clearly.)

Employee Last Name	First MI	Social Security # - -
Street Address		Phone Number

City	State Zip Code	Date of Birth	Employee #
Contract Group	Hours Per Week	Employee Hire Date	

SECTION 2 – REASON FOR CHANGE/ENROLLMENT

- ☒ Open Enrollment
- ☐ Declining Coverage
- ☐ Adding Dependents
- ☐ Dropping Dependents
- ☐ Other:_____

SECTION 3 – DENTAL PLAN

- ☐ Dental Coverage
- ☐ Decline Dental

- ☐ Single
- ☐ Single + 1
- ☐ Family

Effective Date: 7 / 1 / 2023

SECTION 4 – EMPLOYEE AND DEPENDENT INFORMATION

Add	Drop	Relationship to Employee	First Name, Middle Initial (last name only if different from employee)	Gender	Date of Birth (required)	Social Security #
☐	☐	Employee				
☐	☐					
☐	☐					
☐	☐					
☐	☐					

SECTION 5 – EMPLOYEE SIGNATURE

I understand that this election cannot be revoked or changed until the next open enrollment period, unless there is a loss of eligible or life event. The change must be made within 30 days from the date of the life event.
(Please contact your Human Resources generalist or refer to the benefits booklet for the life event information.)

_____ _____
EMPLOYEE SIGNATURE DATE SIGNED

☐ My Spouse is also employed with the district

For HR Use Only EFP: DeltaDen: HRS: Audit:

Deductions: ☐ Full Year ☐ August ☐ September ☐ October