

CFPB Dental enrollment/ change form



A. Reason for enrollment/change

New enrollment

Add or delete dependents

Change of address

Qualifying event

Open Season

B. Personal information

FIRST NAME

LAST NAME

MI

SOCIAL SECURITY NUMBER (No Dashes)

DATE OF BIRTH (MM/DD/YYYY)

MARITAL STATUS

Married

Single

Divorced

GENDER

Male

Female

STREET ADDRESS

APARTMENT

CITY

STATE

ZIP

EMAIL

HOME TELEPHONE

WORK TELEPHONE

C. Dependents (List all covered dependents. Use page the continuation sheet to add more dependents.)

Note: If a dependent is a full-time student age 22 or older, or up to age 25, student verification will be requested. When enrolling a domestic partner, please ensure that an Affidavit of Domestic Partnership for Benefits Coverage is on file with the Human Capital office.

FIRST NAME

LAST NAME

MI

SOCIAL SECURITY NUMBER (No Dashes)

DATE OF BIRTH (MM/DD/YYYY)

ELIGIBILITY

Spouse

Domestic Partner

Dependent

GENDER

Male

Female

C. Dependents (continued)

FIRST NAME	LAST NAME	MI	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
SOCIAL SECURITY NUMBER (No Dashes)	DATE OF BIRTH (MM/DD/YYYY)	ELIGIBILITY	GENDER
<input type="text"/>	<input type="text"/>	Spouse Domestic Partner Dependent	Male Female

FIRST NAME	LAST NAME	MI	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
SOCIAL SECURITY NUMBER (No Dashes)	DATE OF BIRTH (MM/DD/YYYY)	ELIGIBILITY	GENDER
<input type="text"/>	<input type="text"/>	Spouse Domestic Partner Dependent	Male Female

FIRST NAME	LAST NAME	MI	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
SOCIAL SECURITY NUMBER (No Dashes)	DATE OF BIRTH (MM/DD/YYYY)	ELIGIBILITY	GENDER
<input type="text"/>	<input type="text"/>	Spouse Domestic Partner Dependent	Male Female

FIRST NAME	LAST NAME	MI	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
SOCIAL SECURITY NUMBER (No Dashes)	DATE OF BIRTH (MM/DD/YYYY)	ELIGIBILITY	GENDER
<input type="text"/>	<input type="text"/>	Spouse Domestic Partner Dependent	Male Female

Signature

EMPLOYEE SIGNATURE	DATE
<input type="text"/>	<input type="text"/>

HC SIGNATURE	DATE	EFFECTIVE DATE OF COVERAGE
<input type="text"/>	<input type="text"/>	<input type="text"/>

(Return completed form to CFPB_HRBenefits@cfpb.gov)