

**STATE OF OHIO  
DENTAL AND VISION ENROLLMENT AND CHANGE FORM  
EXEMPT EMPLOYEES**

**TO BE COMPLETED BY EMPLOYEE (PLEASE PRINT)**

Last Name		First		M.I.
Street Address		City	State	Zip Code
Employee ID Number	DOB	Office Telephone #		County

Open Enrollment  Marriage  Transfer Agencies  Birth, Adoption, Custody, Guardianship   
 New Enrollment  Divorce  Change Bargaining Unit to Exempt  Date of Event \_\_\_\_\_  
 Other Change (Explain)  : \_\_\_\_\_

**BENEFITS SELECTION**

**Dental Plan:**

Decline  Elect  Single  Family  **Delta Dental PPO**  **Delta Dental Premier**

**Vision Plan:**

Decline  Elect  Single  Family  **Vision Service Plan**  **Eye Med Vision Care**

**DEPENDENT INFORMATION** (If extra space is needed, use an additional form)

Name (Last, First, M.I.)	Sex	Date of Birth	Relationship (Circle)	Social Security Number	Add To: (Circle)	Drop From: (Circle)
			S C O		D V	D V
			S C O		D V	D V
			S C O		D V	D V
			S C O		D V	D V
			S C O		D V	D V
			S C O		D V	D V

**Codes: S=Spouse C=Child O=Other Dependent D=Dental V=Vision**

**Dependent's address if different from employee's address:** (if more space is needed, attach additional sheet)

Dependent's Name: \_\_\_\_\_ Address: \_\_\_\_\_

**Dependents over age 19 (age 23 if disabled) require documentation of eligibility unless an affidavit is already on file for coverage under your State of Ohio health insurance.**

**CERTIFICATION**

I certify the above information about me and/or my dependents to be accurate.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

**(Agency)  
Place original in employee file after initiating coverage. Do not send to Benefits Administration Services.**

Exempt employee dental coverage is provided by Delta Dental plan of Ohio. When making your coverage selection, be sure to check with your dentist to determine whether he/she belongs to the Delta Dental PPO or Delta Dental Premier network.

Vision coverage is provided by Vision Service Plan (VSP) and Eyemed Vision Care. Both have large Ohio networks but you should check with your vision care provider to confirm their participation in these plans before enrolling.

For additional information on these plans please visit the Benefits Administration website at: <http://das.ohio.gov/Divisions/HumanResources/BenefitsAdministration.aspx>.

**Eligibility and Effective Dates of Coverage:** Employees must enroll for dental and vision coverage within 31 days of reaching one year of continuous state service, or during any open enrollment period following the attainment of one year of state service. Coverage is effective the first of the month following your one-year anniversary date, or July 1<sup>st</sup> if you enroll during an open enrollment period.

Service time for employees classified as student help, college interns or whose appointments are temporary, seasonal or intermittent may count toward one year of continuous state service if such employees are hired on a permanent, full-time basis or permanent part-time basis with no break in service. Please contact your payroll/personnel officer to confirm your eligibility.

### **Married State Employees**

When spouses are both employed by the state, both employees may not carry family coverage. You have the following options:

- Both may carry single coverage,
- Both may be covered by one family plan, or
- One employee may carry family coverage and the other single, but the spouse with single coverage may not be listed as a dependent under the family plan.

### **Exempt Employees Plan Contact Information**

**Delta Dental Plan of Ohio:** Customer service, 1-800-524-0149; [www.deltadentaloh.com](http://www.deltadentaloh.com)

**Vision Service Plan (VSP):** Customer service, 1-800-877-7195; [www.vsp.com](http://www.vsp.com)

**Eye Med Vision Care:** Customer service, 1-866-723-0514; [www.eyemedvisioncare.com](http://www.eyemedvisioncare.com)