

**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 Web site at: <http://das.ohio.gov/hrd/benindex.html>.

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 1st 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

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

Eye Med Vision Care: Customer service, 1-866-723-0514; www.eyemedvisioncare.com