

J.J. STANIS and COMPANY, INC.
 377 Oak Street • Suite 406
 Garden City • New York 11530

**NON-CONTRIBUTORY DENTAL
 ENROLLMENT CARD**
 (PLEASE PRINT ALL INFORMATION)

Phone (516) 465-3900
 Fax (516) 465-3920

Policy Holder: Dutchess Community College Faculty (200) Administrator (201)
 Insured Name: (Last) _____ (First) _____
 Home Address: _____ City: _____ State: _____ Zip: _____
 Date of Birth: _____ Sex: Male Female
 Social Security Number: _____ Date of Employment: _____
 Annual Salary: _____ Hours worked weekly: _____
 Marital status: Single Married Widowed Divorced Separated

INFORMATION FOR DEPENDENTS

Do you now have eligible dependents? Yes No - If yes, are they to be included in the plan? Yes No (If yes, please list your dependents below)

First Name	Last Name	Date of Birth Month-Day-Year	Social Security Number	Relationship	Other Coverage?	Sex
_____	_____	_____	_____	<input type="checkbox"/> Spouse	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M <input type="checkbox"/> F
_____	_____	_____	_____	<input type="checkbox"/> Child	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M <input type="checkbox"/> F
_____	_____	_____	_____	<input type="checkbox"/> Child	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M <input type="checkbox"/> F
_____	_____	_____	_____	<input type="checkbox"/> Child	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M <input type="checkbox"/> F
_____	_____	_____	_____	<input type="checkbox"/> Child	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> M <input type="checkbox"/> F

I am applying for Individual OR Family Coverage Date of Marriage : _____

Request to participate (check one)

Reason for refusing coverage:

Waiver of insurance

I do not wish to participate in this insurance program offered through my employer, and I understand that evidence of insurability satisfactory to the insurance company may be required if I desire to participate in the plan at a later date.

Signed: _____

Signature of Employee

Signed: _____

Signature of Employee

Date: _____

Date: _____