**NORTHERN BUCKEYE EDUCATION COUNCIL**
**COORDINATION OF DENTAL BENEFITS FORM**

**For NBEC Administrative Use Only**

| PLAN # | LOCATION | STATUS | | EFFECTIVE DATE | VERIFIED BY |
|---|---|---|---|---|---|
| D-3 | NSA | A | | | |

**In order to update our records, please provide the following information:**

| PLAN NAME<br>**Northern Buckeye Education Council** | | | CLIENT #<br>**817** | SCHOOL<br>**NORTHWEST STATE COMMUNITY COLLEGE** | |
|---|---|---|---|---|---|
| EMPLOYEE NAME | FIRST | M.I. | LAST | EMPLOYEE SOCIAL SECURITY # | EMPLOYEE DATE OF BIRTH |
| | | | | | |

**ARE YOU OR ANY OF YOUR DEPENDENTS COVERED BY ANOTHER GROUP PLAN? ☐ YES ☐ NO**

**IF YES, PLEASE COMPLETE THE FOLLOWING FOR THE INSURED PERSON**

| NAME OF INSURED PERSON | GENDER | BIRTHDATE | SOCIAL SECURITY NUMBER |
|---|---|---|---|
| | | | |

IS THE INSURED PERSON RETIRED? ☐ YES ☐ NO

**IF NO, PLEASE PROVIDE THE FOLLOWING EMPLOYER INFORMATION**

| EMPLOYER NAME | EMPLOYER STREET ADDRESS | EMPLOYER CITY | EMPLOYER STATE | EMPLOYER ZIP |
|---|---|---|---|---|
| | | | | |

**PLEASE LIST DEPENDENTS COVERED BY ANY OTHER GROUP PLAN**

| DEPENDENT NAME #1 | DEPENDENT NAME #2 | DEPENDENT NAME #3 | DEPENDENT NAME #4 | DEPENDENT NAME #5 |
|---|---|---|---|---|
| | | | | |

**PLEASE PROVIDE THE FOLLOWING INFORMATION FOR ANY OTHER INSURANCE COMPANY/ORGANIZATION PROVIDING BENEFITS**

| NAME OF INSURANCE COMPANY | STREET ADDRESS | CITY ST ZIP | PHONE |
|---|---|---|---|
| POLICY PLAN NUMBER | EFFECTIVE DATE | | |
| NAME OF INSURANCE COMPANY | STREET ADDRESS | CITY ST ZIP | PHONE |
| POLICY PLAN NUMBER | EFFECTIVE DATE | | |

**I agree to immediately report any changes to any of the information included on this form.**

_____
EMPLOYEE SIGNATURE DATE

**Please return this completed form to your school's Human Resources office.**