CAPE GIRARDEAU
PUBLIC SCHOOLS

Dental Insurance Enrollment Form

Employee Name: _____**Effective Date:**_____

Coverage Tiers:

_____	Employee	$23.94 (Board-paid)
_____	Employee/Spouse	$22.62
_____	Employee/Child(ren)	$24.34
_____	Employee/Family	$49.54

If applying for dependent coverage list spouse and unmarried eligible children:

Name	Social Security	Relationship	Date of Birth