



***** OPEN ENROLLMENT 2026 *****
DENTAL/VISION ENROLLMENT FORM
Orange County Self-Insured



DENTAL	☐ Family	☐ Individual	☐ Decline	
VISION	☐ Family	☐ Individual	☐ Decline	
Last Name		First Name	MI	
Street Address		Social Security Number		
City	State	Zip Code	Date of Birth	
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced			Date of Marriage	
☐ Decline Coverage			Date of Hire	
☐ Request Enrollment – Individual		☐ Request Enrollment – Family Complete Dependent Information		
☐ Change Name – Previous Name Was:				
☐ Change To Individual - Reason:			Date:	
☐ Change To Family - Reason:			Date:	
☐ Add a dependent - Reason:			Date:	
☐ Remove a dependent - Reason:			Date:	
List Name of Dependent(s) to be Added or Removed				
Last Name	First Name/ MI	Date of Birth	Relationship	Social Security No.

Note: Relationship: Sp-Spouse, Dtr-Daughter, Son-Son, S/Son-Stepson, S/Dtr-Stepdaughter, L/G-Legal Guardianship

Is your spouse employed by Orange County OR Orange County Community College YES _____ NO _____

YOU MUST PROVIDE PROOF for all dependents being added to your coverage for the first time:

copy of government issued marriage certificate if adding spouse, birth certificate(s), social security card(s), legal guardianship papers, etc.

Remove dependents as soon as they are no longer eligible; you must remove ex- spouse as soon as divorce is final.

Copy of the divorce decree (first and last page) and ex- spouse's most recent address are required.

I understand that if I am required to make contributions as a result of this request, my employee contributions for the benefit will be taken on a pre-tax basis (IRS Section 125) unless I notify Risk Management, in writing, to the contrary.

SIGNATURE: _____ DATE: _____

Department: _____

For Risk Use Only:

Group No.	Dept No.	Effective Date	Documents on File	O.C.S.I	EH	EX	EL