



Employer use only: Effective Date: _____

**SUPPLEMENTAL ENROLLMENT FORM
FOR NAPEBT – 1331**

***Please complete Delta Dental Enrollment form in addition to this supplemental form.**

EMPLOYEE'S SOCIAL SECURITY #: XXX-XX- _____
Last 4 digits only

EMPLOYEE'S NAME: _____

BASE PLAN

Division/Class: 1331-0001

\$1,000 Annual Benefit (provided for all employees eligible for dental coverage and paid for by Coconino County.)

- Employee only Free
- Dependents \$40.87 per month / \$20.44 per pay period

BUY UP PLAN

Division/Class: 1331-0003

\$2,000 Annual Benefit Buy-up Option (Coverage is voluntary and paid for by the member.)

BUY-UP: I would like to enroll in the Delta Dental Buy-up program indicated below. I agree to have the premiums deducted through payroll. I understand that employees must enroll to make dependents eligible for this option. If I elect family coverage, I cannot elect single buy-up coverage.

- Employee Only \$3.46 per month / \$1.73 per pay period
- Employee + Family \$45.33 per month / \$22.67 per pay period
(\$4.46 more per month than \$1,000 annual benefit)

Signature

Date

Please return form to Coconino County Human Resources Benefits Department

Do Not Return to Delta Dental

For employer Use only

Payroll Processing date:	Initial:
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