GROUP DENTAL ENROLLMENT FORM

☐ New Employee	☐ Decline Coverage	☐ Add/Delete Dep.	☐ Transfer from DHMO	☐ Cancel Coverage
☐ Rehire	☐ Address/Name Change	☐ Loss of Other Coverage	☐ Transfer from PPO	☐ COBRA

Name of Employer:	**Group Number:**

☐ **DHMO Dental Plan** #____________________
Dental Office Selected

Social Security Number:	**Effective Date** Mo / Day / Year	**Date Employed Full Time** Month / Day / Year	**Hours Worked** Per Week
Last Name: First Name: MI:		**Date of Birth** Month / Day / Year	**Sex:** Male ☐ Female ☐

Home Address: **Street:**______________________________ **Apartment #** ______________________________ **City, State, Zip:**______________________________ **Home Phone:**__________________ **Work Phone:** _________________ **Do you have other Dental Coverage? If yes, Carrier:**	**Coverage Requested:** ☐ Employee Only ☐ Employee + 1 Dependent ☐ Family

Complete for Dependent Coverage:

Spouse Name-Last: **First:** **MI:**	**Date of Birth:**	**Sex:**
	/ /	
CHILDREN 1.	/ /	
2.	/ /	
3.	/ /	
4.	/ /	
5.	/ /	
6.	/ /	

I hereby authorize payroll deduction, if applicable, and agree that in order to be covered by TDAHP; services must be obtained from or ordered by a TDAHP plan provider, except for emergencies. I hereby apply for enrollment and agree to remain in the plan a minimum of one year, authorize the release of any information relating to dental care received under the plan, and to all terms and conditions set forth in the Group Agreement.

Employee Signature: **Date:**

Refusal of Group Dental Coverage: I have been offered this insurance coverage and decline to purchase it at this time. I understand that in the event I desire such insurance at a later date, I will need to wait until Open Enrollment.

Employee Signature: **Date:**

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