



## GROUP DENTAL ENROLLMENT FORM

<input type="checkbox"/> New Employee	<input type="checkbox"/> Decline Coverage	<input type="checkbox"/> Add/Delete Dep.	<input type="checkbox"/> Transfer from DHMO	<input type="checkbox"/> Cancel Coverage
<input type="checkbox"/> Rehire	<input type="checkbox"/> Address/Name Chg	<input type="checkbox"/> Loss of Other Coverage	<input type="checkbox"/> Transfer from PPO	<input type="checkbox"/> COBRA

Name of Employer: _____	Group Number: _____
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DHMO Dental Plan # \_\_\_\_\_  
 Dental Office Selected \_\_\_\_\_

<b>Social Security Number:</b> _____	<b>Effective Date</b> Mo / Day / Year	<b>Date Employed Full Time</b> Month / Day / Year	<b>Hours Worked Per Week</b>
<b>Last Name:</b> _____	<b>First Name:</b> _____	<b>MI:</b> _____	<b>Date of Birth</b> Month / Day / Year
			Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>

<b>Home Address:</b> Street: _____ Apartment # _____ City, State, Zip: _____ Home Phone: _____ Work Phone: _____ Do you have other Dental Coverage? If yes, Carrier: _____	<b>Coverage Requested:</b> <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + Child(ren) <input type="checkbox"/> Family
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**Complete for Dependent Coverage:**

<b>Spouse Name-Last:</b> _____	<b>First:</b> _____	<b>MI:</b> _____	<b>Date of Birth:</b>	<b>Sex:</b>
			/ /	
<b>C H I L D R E N</b>	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: \_\_\_\_\_