



## 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 Change	<input type="checkbox"/> Loss of Other Coverage	<input type="checkbox"/> Transfer from PPO	<input type="checkbox"/> COBRA

Name of Employer:	Group Number:	Div:	Class:
-------------------	---------------	------	--------

Plan Types: <input type="checkbox"/> PPO Plan
--

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

<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"/> Family
---	---

<b>Complete for Dependent Coverage:</b>	<b>Do any of your dependents have other dental coverage? If yes, list Carrier below</b>
---	---

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

**I elect the dental coverage** selected for which I am eligible. If any contribution from me is necessary to pay part of the cost of insurance. I authorize my employer to deduct the contribution from my wages. 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.

**Date:** \_\_\_\_\_ **Employee Signature:** \_\_\_\_\_

**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 be required to furnish evidence of insurability at my own expense, and the company will have the right to refuse any request.

**Date:** \_\_\_\_\_ **Employee Signature:** \_\_\_\_\_