TDA
Total Dental Administrators, Inc.

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:	Div:	Class:

Plan Types:

☐ **PPO Plan**

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:

Do any of your dependents have other dental coverage? If yes, list Carrier below

	Spouse Name-Last:	First:	MI:	Sex:	Date of Birth:	Name of Other Dental Carrier:
					/ /	
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:**

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