



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

Home Address: Street: _____ Apartment # _____ City, State, Zip: _____ Home Phone: _____ Work Phone: _____ Do you have other Dental Coverage? If yes, Carrier: _____	Coverage Requested: <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:	Do any of your dependents have other dental coverage? If yes, list Carrier below
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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:** _____