

DENTAL ENROLLMENT FORM - EMPLOYEE

For New Enrollment, please complete all sections of this form. If you are enrolling for employee-only coverage, you do not need to fill in the Dependent Information section. For Enrollment Changes, please complete the type of Activity and Only the applicable changes along with the employee name and ID number.

General Information:

Group Size:	Plan Type:	Type of Activity:	
<input type="checkbox"/> Group of 1 (sole proprietor)	<input type="checkbox"/> High	<input type="checkbox"/> New Enrollment	<input type="checkbox"/> Plan Change (please specify):
<input type="checkbox"/> Group of 2 or more	<input type="checkbox"/> Medium		<input type="checkbox"/> Add Dependent
	<input type="checkbox"/> Low		<input type="checkbox"/> Cancel All Coverage (Enrollee & All Dependents)
	<input type="checkbox"/> Basic		<input type="checkbox"/> Cancel Dependent(s) Only
			<input type="checkbox"/> Change Address
			<input type="checkbox"/> Change of Employee Status (contract change)
			<input type="checkbox"/> Reinstate Coverage (allowed once/12months)
			<input type="checkbox"/> Change Name
			<input type="checkbox"/> Change Provider
			<input type="checkbox"/> Other _____

Group Information:

Group Name: _____ Group Number: _____

Group Administrator/HR Manager/ Group Contact: _____

Employee Information: ID Number/SS#: _____ Original Employment Date: _____

Employee Name (Last, First, Middle Initial): _____

Home Address: _____ City: _____ St: _____ Zip: _____

Date of Birth: _____ Sex: _____ e-mail: _____

Employee Home Phone: _____ Fax: _____

Dependent Information:

(If dependent children listed below are handicapped or full-time students age 19 or over, please see your group administrator for a dependent certification form, complete and attach the form to this application.)

Social Security #	Type	Last Name	First Name	MI	Sex	Date of Birth
	Spouse					
	Dependent					
	Dependent					
	Dependent					
	Dependent					

I represent that all the information supplied in this application is true and correct. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

Employee Signature: _____ Date: _____

Employer/Administrator Signature: _____ Date: _____

Employer/ Administrator Phone Number: _____