DENTAL PLAN ENROLLMENT FORM

Please print or type - **Note: You are not covered until this form is received by Administrator.**

Employee Name _____ _____ _____ _____
Last, First, MI Birth Date Hire Date SS or EE #

Address/Phone _____ _____ _____
Street City/zip Phone

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

If you are married, does your spouse work? If so, please complete the following:

Name of Employer_____

Address/Phone _____ _____ _____
Street City/zip Phone

Do you have unmarried children under age 19 who are dependent on you? ☐ Yes ☐ No

Do you and/or your spouse have any other dental coverage? ☐ Yes ☐ No

Do you have unmarried dependent children between age 19 and 23 who are full time students? ☐ Yes ☐ No

Are those children enrolled in any other dental coverage ? ☐ Yes ☐ No

If yes to above, insurance company name_____

Dental Coverage will apply to:
☐ Employee Only ☐ Employee & Spouse
☐ Employee, Spouse & Children ☐ Employee & Child(ren) Only

I am applying: ☐ For New Enrollment ☐ As a Rehire ☐ To Add Dependents

List all dependents by name, SS#, date of birth, gender and realtionship

Name	SS#	Date of Birth	Gender	Relationship

I have received the Summary Plan Description provided by my employer

Employee_____ Date _____

I hereby request coverage under my employer's dental plan. I represent that the answers I have given are full, complete and true.

Employee_____ Date _____

☐ Waiver of coverage
I have been given the opportunity to apply for dental coverage under the dental plan offered through my employer and have decided not to accept the offer for:
☐ Myself ☐ Spouse ☐ Child(ren)

Should I desire to apply for dental coverage in the future, I realize that I must wait until the open enrollment period.

Employee _____ Date _____