

Dental Insurance

Enrollment Application

*Entire form must be completed.
Coverage subject to approval.*

New Enrollment: Employee Employee & Spouse Employee & Child(ren) Employee, Spouse & Child(ren)

Change: Add (check one or both) Spouse Child
 Terminate (check all that apply) Employee Spouse Child

I would like to pay on a **pre-tax** basis. I understand that any change I need to make to my dental benefits can only take place within 31 days of a qualify change of status event, in accordance with Section 125 regulations

I would like to pay on a **post-tax** basis.

If neither box is checked, the current election will remain (or post-tax if new enrollment).

Part A: Employee / Subscriber Information

First name _____ Initial _____ Last Name _____ Date of birth ___ / ___ / ___
Mo Day Year

Street Address _____ APT# _____ Daytime Phone Number _____

City _____ State _____ Zip _____ Soc Sec Number ___ - ___ - ___

Marital Status: Single Married Gender: Male Female

Do you currently have other dental coverage? ___ (Y/N) *If yes, complete the following:*

Policyholder's name _____ Name of Employer _____

Policy # _____ Name of Carrier _____

Part B: Dependent Information

List the eligible family members you wish to enroll/add/delete.

| | Add | Drop | First Name | MI | Last Name | Social Security Number | Date of Birth (Mo/Day/Year) | Gender (M/F) | Other Coverage? (Y/N) |
|--------|--------------------------|--------------------------|------------|----|-----------|------------------------|-----------------------------|--------------|-----------------------|
| Spouse | <input type="checkbox"/> | <input type="checkbox"/> | | | | ___-___-___ | (___/___/___) | | |
| Child | <input type="checkbox"/> | <input type="checkbox"/> | | | | ___-___-___ | (___/___/___) | | |
| Child | <input type="checkbox"/> | <input type="checkbox"/> | | | | ___-___-___ | (___/___/___) | | |
| Child | <input type="checkbox"/> | <input type="checkbox"/> | | | | ___-___-___ | (___/___/___) | | |
| Child | <input type="checkbox"/> | <input type="checkbox"/> | | | | ___-___-___ | (___/___/___) | | |

Employee Signature _____ Date ___ / ___ / ___
Mo Day Year

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Part C: To be Completed by the Employer

Effective Date ___ / ___ / ___ Campus Name: _____
Mo Day Year

Group # _____ Applicant's Hire Date: ___ / ___ / ___
Mo Day Year