Dental Enrollment Form

## Basic Information

|  |  |  |  |
| --- | --- | --- | --- |
| Full Name | Enter Full Name | Social Security# | Social Security# |
| Address | Address | City, STATE, ZIP | City, STATE, ZIP |
| Telephone# | Home/Work | Gender | Male/Female/Other |
| Date of Birth | DD/MM/YYYYY | Company Name | Company Name |
| Insurance Plan | Single/Single+Spouse/Single+Child(ren)/Family | | |

## Information for Dependent Coverage

|  |  |  |
| --- | --- | --- |
| Spouse & Unmarried Dependent Children Only (Include Date of Birth) | | |
| Full Name | Date of Birth | Relationship |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

## For Office Use Only

## Employer authorization:

|  |
| --- |
|  |

Effective Date:

## Type of coverage

Write here…

I hereby understand that any coverage is limited by the benefits and exclusions of the Group Dental Agreement

|  |  |  |  |
| --- | --- | --- | --- |
| Signature: |  | Date: |  |

\*Minimum enrollment is one year