

Dental Insurance

Enrollment Application Entire form must be completed. Coverage subject to approval.

New Enrollment: Employee		Employee & S	Spouse	Employee & Child(ren)		Employee, Spouse & Child(ren)		
•	ck one or both) e (check all that	•	Child loyee	Spouse	Child			

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.

Part A: Employ	yee / Sub	scriber Infor	mation						
First name		Initial _	Last	Last Name		Date of birth/ _/ /			
Street Address _			AP	Γ#	Daytime	Phone Number			
City		State	9		Zip	Soc Sec Number			
Marital Status:	Single	Married	Gender:	Male	Female				
Do you currently	have other	dental covera	ge? (Y/N) If ye	s, complete tl	ne following:			
Policyholder's na	ame			Name	of Employer				
Policy #		Nan	ne of Carrier						

Part B: Dependent Information

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

	Add	Drop	First Name	мі	Last Name	Social Security Number	Date of Birth (Mo/Day/Year)	Gender (M/F)	Other Coverage? (Y/N)
Spouse							(/)		
Child							(/)		
Child							(/)		
Child							(/)		
Child							(/)		

Employee Signature _

Date ___/ ___/ ____

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:

Group # _____

Applicant's Hire Date: ____ / ___ / ____