

GROUP DENTAL ENROLLMENT CARD

Please make additional copies of this form if needed.

Employer's Business Name _____

Address _____

City _____ State _____ Zip Code _____

Telephone Number _____ Account Number _____

Employee

Last Name _____ First Name _____ Middle Initial _____

Address _____

City _____ State _____ Zip Code _____

Soc. Sec.#:

Male Female Date of Birth: Mo. ____ Day ____ Yr. ____

Single Married Occupation: _____

Date of Full-Time Employment: Mo. ____ Day ____ Yr. ____

Date of Part-Time Employment: Mo. ____ Day ____ Yr. ____

Do you work at least 30 hours per week at this company? Yes No (If No, not eligible)

Are you applying for dental coverage? Yes No

Name of present dental insurance carrier: _____ Date dental coverage terminates: Mo. ____ Day ____ Yr. ____

Is your Spouse to be insured for dental coverage? Yes No Is your Spouse covered elsewhere? Yes No

Are your Children to be insured for dental coverage? Yes No Are your Children covered elsewhere? ... Yes No

I request insurance under my Employer's Group Insurance plan as now or hereafter applicable to me, and authorize my Employer to make deductions from my earnings for my share of the cost, if any, of the benefits to which I may become entitled.

I represent that the answers I have given are full, complete and true.

Signature: _____

Date Signed: _____

To Be Completed by Trust Administrator

Dental Coverage Effective:

Dependent Coverage:

- Spouse Only
- Children Only
- Spouse & Children
- None