HealthPlan *Services*

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