

Dental Insurance

Enrollment Application

Entire form must be completed.
Coverage subject to approval.

EBEN - 105

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"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	(<input type="text"/> / <input type="text"/> / <input type="text"/>)	<input type="text"/>	<input type="text"/>
Child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	(<input type="text"/> / <input type="text"/> / <input type="text"/>)	<input type="text"/>	<input type="text"/>
Child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	(<input type="text"/> / <input type="text"/> / <input type="text"/>)	<input type="text"/>	<input type="text"/>
Child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	(<input type="text"/> / <input type="text"/> / <input type="text"/>)	<input type="text"/>	<input type="text"/>
Child	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	(<input type="text"/> / <input type="text"/> / <input type="text"/>)	<input type="text"/>	<input type="text"/>

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