

DentalNOW!sm BASIC PLAN INSURANCE ENROLLMENT FORM

ADMINISTRATION USE

I am: ___ New Enrollee ___ Re-Enrollee ___ Adding Dependent(s) ___ Changing Previous Information

My Name is: First _____ Middle _____ Last _____

My Permanent Address is: Street _____ City _____ State _____ Zip _____

I am: Male Female My Birthdate is: / / My Social Security Number is: / /
month day year

My Employer is: _____ Date of Hire: / /
month day year

My Occupation and Duties: _____

I would like coverage for: Myself or Myself + 1 or Myself and Family Members

Acct Number

Effective Date

	Name: First/Last (if different than employee's)		Date of Birth
PLEASE LIST ALL ELIGIBLE FAMILY MEMBERS		<input type="checkbox"/> Spouse	___/___/___
		<input type="checkbox"/> Child <input type="checkbox"/> Full-Time Student	___/___/___
		<input type="checkbox"/> Child <input type="checkbox"/> Full-Time Student	___/___/___
		<input type="checkbox"/> Child <input type="checkbox"/> Full-Time Student	___/___/___
		<input type="checkbox"/> Child <input type="checkbox"/> Full-Time Student	___/___/___
		<input type="checkbox"/> Child <input type="checkbox"/> Full-Time Student	___/___/___

I hereby represent that all the information above is true and complete to the best of my knowledge and I authorize my employer to make the required payroll deduction.

Signature _____ Date / /
month day year

WAIVER OF COVERAGE

I have been given the opportunity to enroll in the DentalNow! Insurance Plan, but choose to waive this coverage because I am covered under my spouse's dental plan with _____
Current Carrier name. I understand that if I choose to enroll in the DentalNOW! Plan at a later date, benefits may be limited to Service Type I for 24 months.

I do not have dental coverage under a spouse's plan and I choose to waive this coverage opportunity anyway. I understand that if I choose to enroll in the DentalNOW! Plan at a later date, benefits may be limited to Service Type I for 24 months.

Signature _____ Date / /
month day year