

DentalNOW!SM INSURANCE ENROLLMENT FORM

ADMINISTRATION USE

Acct Number

Effective Date

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: <input type="checkbox"/> Male <input type="checkbox"/> Female My Birthdate is: ___/___/___ My Social Security Number is: _____/_____/_____
My Employer is: _____ Date of Hire: ___/___/___
My Occupation and Duties: _____
I would like coverage for: <input type="checkbox"/> Myself or <input type="checkbox"/> Myself + 1 or <input type="checkbox"/> Myself and Family Members

	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	___/___/___
		<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 ___/___/___

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 ___/___/___