



<b>Office Use Only</b>	Plan:	Account Number:
	Member Number:	Code:

- If you wish to refuse coverage for yourself or a dependent, please complete the waiver at the bottom of the page -

### EMPLOYER SECTION

Please check one box only <input type="checkbox"/> Initial Enrollment <input type="checkbox"/> Change <input type="checkbox"/> Open Enrollment	Effective Date:	Name of Company: (division no.)
	____/____/____ mm dd yyyy	Account Number:

### EMPLOYEE SECTION: Please print all information. Sign and date this form below.

Employee Name:			
Home Address: (street)		(city)	(state) (zip)
Home Phone:	Work Phone	Fax:	
Marital Status:	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced
	<input type="checkbox"/> Domestic Partner	<input type="checkbox"/> Eligible Children: _____	
Date of Hire: ____/____/____	Occupation:	Total hours worked per week:	<input type="checkbox"/> Less than 30 <input type="checkbox"/> More than 30

### BENEFIT COVERAGE OPTIONS:

Group PPO / EPO Dental
<input type="checkbox"/> PPO 1 <input type="checkbox"/> PPO 2 <input type="checkbox"/> PPO 3
<input type="checkbox"/> EPO A <input type="checkbox"/> EPO B <input type="checkbox"/> EPO C
Dental Health Services DHMO (prepaid) Plan
<input type="checkbox"/> Gold Plan <input type="checkbox"/> Silver Plan <input type="checkbox"/> Bronze Plan
* Dental Office Number (DHMO Only) _____

### ENROLLMENT INFORMATION: Please provide all information for yourself and each dependent to be enrolled.

Last Name	First Name	Sex	Birth Date mm/dd/yyyy	Full-time Student*	Social Security	Dentist # (2/family)	Change Status of Dependents
Self		M F		n/a			<input type="checkbox"/> Add <input type="checkbox"/> Remove
Spouse		M F		n/a	n/a		<input type="checkbox"/> Add <input type="checkbox"/> Remove
Child		M F		Y N	n/a		<input type="checkbox"/> Add <input type="checkbox"/> Remove
Child		M F		Y N	n/a		<input type="checkbox"/> Add <input type="checkbox"/> Remove
Child		M F		Y N	n/a		<input type="checkbox"/> Add <input type="checkbox"/> Remove

\* For all dependents age 19 or older, please provide proof that he/she is a full-time student.

I hereby declare that I am a full-time employee of the employer indicated above and that I regularly work for my employer at least 30 hours per week. Additionally, I hereby request the group benefit plans for which I am or may become eligible under the policies or contracts issued by the Insurer or Benefit Provider. I authorize the deductions from my earnings of any contributions I may have to make toward the cost and understand that my request for group benefits shall include this form or any other form which may be required. All information given by me on this form is true and complete and is offered as a request to grand benefit coverages.

**Employee Signature:** X \_\_\_\_\_ **Date:** \_\_\_\_\_

*Dental HMO benefits provided by Dental Health Services.*

### WAIVER OF COVERAGE: Complete this section only if you are refusing dental coverage for yourself or a dependent. Then return this form to your employer.

Refusing coverage for:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child(ren)
Reason for Refusal:	<input type="checkbox"/> Covered under spouse's Group Insurance Plan. Name of Plan: _____		
	<input type="checkbox"/> Other/Explain: _____		
I understand that if I later wish to enroll or re-enroll, I must provide satisfactory evidence of insurability to the Insurance Company or be subject to limited benefits for a specified period of time. I also understand that I may not be eligible for all plans made available through my employer.			
Employee Name (print):	_____		Company Name: _____
Employee Signature: X	_____		Date: _____