

## **Dental Membership Enrollment Form Instructions**

Important Information: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for purposes of misleading, information concerning any fact material thereto, commits a fraudulent act, which is a crime and subjects such person to criminal and civil penalties.

Important notes:

- all dates should be written in MM/DD/YYYY format.
- When reporting effective dates, use contractual start and stop guidelines as defined in your contract (i.e., first of the month, end of month, or actual dates).
- Before submitting, review it to ensure you have provided all necessary information.
- If information is missing or illegible, this form will be returned to you and may delay your enrollment.

**ENROLLMENT, CHANGE OR DECLINE** boxes - Please check appropriate box at top left of your application.

Effective Date is the first of the month.

**EMPLOYEE INFORMATION** - complete name, SS#, occupation, mailing address, city, state and zip code, date of hire, telephone number for home and work, and email address

**ELIGIBLE DEPENDENTS GRID** – complete all information with last name, first name, gender, date of birth, ss#, and other dental coverage for all dependents including yourself. If you need more space for children please list information on back of form.

**REQUEST FOR CHANGE** – indicate reason for termination. You can also change name or address here.

**REQUEST FOR ADDITION** – indicate reason for addition

**EMPLOYEE SIGNATURE AND DATE** – must be completed

Please return completed form to Karen Perry-Thames, HR Coordinator in the business office.