



# Dental Application/Enrollment Form

\*Denotes required fields for enrollment.

|   |                             |                           |  |   |                   |
|---|-----------------------------|---------------------------|--|---|-------------------|
| <b>A DENTAL COVERAGE ELECTION</b>   |                             |                           |  |   |                   |
| I ELECT THE FOLLOWING FOR MYSELF AND MY DEPENDENT(S): <input type="checkbox"/> Dental Plan Code <sup>1</sup> _____  |                             |                           |  |   |                   |
| Type of Coverage: <input type="checkbox"/> Self <input type="checkbox"/> Self/Spouse <input type="checkbox"/> Self/Child <input type="checkbox"/> Self/Children <input type="checkbox"/> Self/Spouse/Child(ren)   |                             |                           |  |   |                   |
| <b>B APPLICANT INFORMATION</b>  |                             |                           |  |   |                   |
| *Last Name  |                             |                           | *First Name  |   | MI                |
| *Gender<br><input type="checkbox"/> Male <input type="checkbox"/> Female  |                             | *Birthdate                |  | *Social Security Number   |                   |
| *Address  |                             |                           |  |   |                   |
| *City   |                             |                           | *State   | *Zip Code   |                   |
| Home Phone  |                             |                           |  |   |                   |
| <b>C FAMILY MEMBERS TO BE COVERED OR DELETED</b>  |                             |                           |  | if address and phone numbers of covered dependents are different from those of policyholder, please attach that information on a separate sheet of paper. |                   |
|   | FULL NAME (Last, First, MI) | SEX                       | RELATIONSHIP   | BIRTHDATE   | SOCIAL SECURITY # |
| <input type="checkbox"/> Enroll<br><input type="checkbox"/> Delete  |                             | M F                       | SPOUSE   | / /   | - -               |
| <input type="checkbox"/> Enroll<br><input type="checkbox"/> Delete  |                             | M F                       |  | / /   | - -               |
| <input type="checkbox"/> Enroll<br><input type="checkbox"/> Delete  |                             | M F                       |  | / /   | - -               |
| <input type="checkbox"/> Enroll<br><input type="checkbox"/> Delete  |                             | M F                       |  | / /   | - -               |
| <b>D OTHER DENTAL COVERAGE</b>  |                             |                           |  |   |                   |
| WHEN coverage BEGINS, will you or any of your family members have any other dental insurance coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No   |                             |                           |  |   |                   |
| <b>E \$</b> _____   |                             |                           |  |   |                   |
| <b>F SIGNATURES (Required)</b>  |                             |                           |  |   |                   |
| <b>Applicant Information and Declaration</b>  |                             |                           |  |   |                   |
| I represent that all information supplied in this application is true and correct. I have thoroughly reviewed, understand, and accurately responded to all questions and information on this application.   |                             |                           |  |   |                   |
| Signature of Applicant/Parent or Legal Guardian<br>X  |                             | Date                      | Signature of Applicant/Parent or Legal Guardian<br>X   |   | Date              |
| Signature of Applicant's Dependent Age 18 or Over<br>X  |                             | Date                      | Signature of Applicant's Dependent Age 18 or Over<br>X |   | Date              |
| <b>Agent Information and Declaration</b>  |                             |                           |  |   |                   |
| To the best of my knowledge, the information on this application is complete and accurate. I have explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information and the applicant understands the explanation. I understand that if I willfully make any false representations I shall, in addition to any applicable penalties or remedies available under current law, be subject to a civil penalty of up to \$10,000. |                             |                           |  |   |                   |
| Signature of Agent<br>X   |                             | Agent Name (Please Print) |  | Agent Number  | Date              |

**Fraud Statements:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. In addition, an insurer may deny insurance benefits if false information materially related to the claim was provided by the applicant.