EMPLOYER'S DENTAL TRUST ENROLLMENT CARD

Account No. 1014-________

❑ New Enrollment ❑ Reinstatement ❑ Change in Dep. Status ❑ Name Change

Employee's Name ______________________________ Date of Birth ______________
(Last, First, MI) (Please Print) (Mo/Day/Yr)

Home Address ____
(No., Street, City, State & Zip Code)

Employer ______________________ Division ______________________

Date Employed Full-time (30 hrs.) ______________ Occupation ______________________
(Mo/Day/Yr)

❑ Male ❑ Female Social Sec. # ______________________

Earnings__________ ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Indicate Selected Coverage:

❑ Employee only ❑ Employee & Spouse ❑ Employee & Child(ren) ❑ Employee, Spouse & Child(ren)

Please List	Last Name	First Name	Date of Birth	Administrative Use only
Spouse:				
Child(ren):				

❑ I accept the Dental Insurance provided by my Employer's Group Insurance plan and authorize deductions from my earnings of the required contributions, if any, toward the cost of this insurance. The authorization only if employee contributions are required.

Date:______________ Signature of Employee: ______________________________
(Sign in ink)

If you are waiving coverage for yourself, spouse, or your dependents, you must also sign reverse side for **Waiver and Refusal.**

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WAIVER AND REFUSAL

❑ Waiver

I do not wish to enroll the following dependent(s) in the Dental Insurance provided by my employer:

Spouse: ______________________________________

Children: ______________________________________

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Are any of the above covered by any other group Dental Plan? ❑ Yes ❑ No

If yes: Name of Group Policyholder: ______________________________

Name of Other Carrier: ______________________________

❑ Refusal

I do not wish to participate in the Dental Insurance provided by my employer.
If refusing coverage, are you covered by another dental plan? ❑ Yes ❑ No

If yes: Name of Group Policyholder: ______________________________

Name of Other Carrier: ______________________________

I understand that I can be subsequently insured for the Group Dental Benefits with limitations. If I can provide satisfactory proof of prior coverage approved by the Insurance Company, benefits will be issued standard.

Date:__________ Signature of Employee: ______________________________