

Refer to instructions on back before completing this form. Print clearly.

Subscriber Group Information - To Be Completed by Sponsor

A. Type of Activity - To Be Completed by Sponsor

Company Name

1. Enrollment <input type="checkbox"/> New Subscriber Effective Date ____ / ____ / ____ Date of Hire ____ / ____ / ____	2. Change - Check all that apply <input type="checkbox"/> Add Spouse <input type="checkbox"/> Add Dependent Child <input type="checkbox"/> Name Change <input type="checkbox"/> Change Plan <input type="checkbox"/> Other	Date of Event ____ / ____ / ____ ____ / ____ / ____ ____ / ____ / ____ ____ / ____ / ____	3. Remove or Terminate <i>Check all that apply</i> <input type="checkbox"/> Remove Spouse <input type="checkbox"/> Remove Dependent Child <input type="checkbox"/> Subscriber Withdrawal/Termination NOTE: Subscriber must be enrolled for spouse/dependent(s) to have coverage.	Effective Date ____ / ____ / ____ ____ / ____ / ____ ____ / ____ / ____	4. Continuation of Coverage, i.e., COBRA Coverage For: <input type="checkbox"/> Subscriber <input type="checkbox"/> Dependents Length of Continuation: <input type="checkbox"/> 12 mos <input type="checkbox"/> 18 mos <input type="checkbox"/> 29 mos <input type="checkbox"/> 36 mos Date of Loss of Coverage: ____ / ____ / ____ Date of Qualifying Event: ____ / ____ / ____
-------------------------------------------------------------------------------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

B. Subscriber Information - Complete Sections B - G.

C. Plan Option

Social Security Number	Last Name, First Name, M. I.		Home Telephone ()		Check One: <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ Your selection must be offered by your Sponsor.
Home Address	Apt. No.	City, State		ZIP Code	
Sponsor Name			Work Telephone ()		
Work Address		City, State		ZIP Code	

D. Individuals Covered - List individuals for whom you are adding/changing/removing coverage. Attach sheet to list add'l. children. Attach proof if f.t. college student.

E. Other Dental Insurance

	(A)dd (C)hange (R)emove	Last Name, First Name, M.I.	Sex M / F	Social Security Number	Birthdate MM / DD / YYYY	
Subscriber					__ / __ / __	Is your Spouse Employed? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", give name & address of spouse's employer. If spouse or dependents have other dental coverage, give name a policy number of insurance carrier, HMO or other source.
Spouse					__ / __ / __	
Child					__ / __ / __	
Child					__ / __ / __	
Child					__ / __ / __	

F. Subscriber Signature

I represent that all of the information supplied in this application is true and complete.

If you have questions concerning the benefits and services provided by or excluded under the Plan, contact a Member Services representative at 1-888-843-4727 before signing this form.

G. Sponsor Verification - To Be Completed by Sponsor

Subscriber Signature - Required	Date ____ / ____ / ____	Sponsor Signature - Required	Title	Date ____ / ____ / ____
----------------------------------------	-----------------------------------	-------------------------------------	--------------	-----------------------------------