

Employee Enrollment Form

Please complete this form by printing in ink or typing.

Name _____

Address _____

City _____ State _____ Zip Code _____

Home Phone (_____) _____

Work Phone (_____) _____

Social Security Number _____

Date of Birth ____/____/____ Circle One M or F

Please indicate your primary language here: _____

Disabilities that affect communication _____

Special Rates For	
	Monthly Rates
Employee Only	\$
Employee & Spouse	\$
Employee & Child(ren)	\$
Employee & Family	\$
Plan: Premier 110-01	
Proposed Effective Date _____	

IMPORTANT

Please select a Family Dentist for you and your family from the OraQuest Dentist Directory and indicate your choice here. If you do not choose a Dentist, one will be assigned for you.

Dr. _____ OraQuest Provider# _____

For Administrative Use Only

Contract Number _____

I wish to cover the following eligible family members:

Name	Sex	Date of Birth
Spouse _____	M F	____/____/____
Child _____	M F	____/____/____
Child _____	M F	____/____/____
Child _____	M F	____/____/____
Child _____	M F	____/____/____
Child _____	M F	____/____/____

I hereby apply for membership in ODP for myself and for any eligible dependents listed above, and authorize my employer/organization to make deductions, if any, required as my contribution for the premium.

- I agree, for myself and for any eligible dependents listed, to abide by the rules and regulations of ODP and the terms and conditions of the Group Dental Service Agreement. This enrollment form shall constitute a part of that agreement.
- I represent that the information provided is true and correct to the best of my knowledge. I understand that my coverage and benefits may be effected by failure to provide complete and accurate information. I will promptly advise ODP and my employer of any changes in this information

I HAVE READ AND UNDERSTAND THE ABOVE STATEMENTS

Signature of Applicant

Date