

Name of Employer (Use Name from Group Billing Notice or Master Application)	Group Number	DIV	CLASS
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To Be Completed by All Employees

<u>Social Security number</u>	<u>Effective Date</u> Month / Day / Year / /	<u>Date Employed Fulltime</u> Month / Day / Year / /	<u>Hours Worked per Week</u>
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<u>Your Name (Last), (First), (Middle Initial)</u>	<u>Date of Birth</u> Month / Day / Year / /	Sex Male <input type="checkbox"/> Female <input type="checkbox"/>
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<u>Home Phone:</u>	<u>Work Phone:</u>
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<u>Home Address:</u> _____ _____ _____	Coverage Requested <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + Child(ren) <input type="checkbox"/> Employee + Family
Do you have any other Dental coverage? If so, Carrier _____	

(Complete for Dependent Coverage)

<u>Spouse Name (Last), (First), (Middle Initial)</u>			DOB	Do any of your dependents have any other dental coverage?	If so, Name of Carrier
	M or F		/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	
C H I L D R E N	1	M or F	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	2	M or F	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	3	M or F	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	4	M or F	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	5	M or F	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Fraud Warning (Not Applicable in AZ, FL, MD or VA): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits (in TX, may be committing) a fraudulent insurance act, which is a crime and subjects (in KS, which may be determined by a court of law to be a crime which subjects) such person to criminal an civil penalties.

Fraud Warning (FL only): Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

I elect the dental coverage selected for which I am eligible. If any contribution from me is necessary to pay part of the cost of insurance, I authorize my employer to deduct the contribution from my wages.

Date _____ **Employee Signature:** _____

Refusal of Group Dental Coverage: I have been offered this insurance coverage and decline to purchase it at this time. I understand that in the event I desire such insurance at a later date, I will be required to furnish evidence of insurability at my own expense, and the company will have the right to refuse any request.

Date _____ **Employee Signature:** _____