



# Dental Enrollment Form (or waiver)

<b>Group No.</b>	<b>Employer:</b>	<b>Date Hired</b>				
		Month	Day	Year		
<b>Employee Name</b> (Last, First, Middle)	<b>Gender</b>		<b>Date of Birth</b>		<b>Social Security #</b>	
	M <input type="checkbox"/>	F <input type="checkbox"/>	Month	Day	Year	

**If enrolling for coverage, please complete this section**

**I am enrolling for dental coverage as indicated:**                      **Dental Choice Plan Option:**

Employee only  
  Employee/Child  
  Employee/Spouse  
  Family                     
  Basic Plan  
  High Plan

**Employee Statement - Enrolling for Coverage**

I understand that on the effective date of my insurance coverage, I must meet each of the following conditions:  
 (a) I must be actively at work and able to perform all duties of my occupation;(b) I must be regularly working on a full-time basis at my employer’s business establishment or at some other location to which my employer’s business requires me to travel, and (c) I have completed any applicable waiting period.

I certify that I meet each of the above conditions and understand that I will not be covered otherwise. I authorize my employer to make deductions from my earnings, if contributions are required. I further understand that if I do not make the required written application within thirty one (31) days of my eligibility date, the group dental benefits will be subject to a one-year waiting period which begins on the date I make written application.

_____ <b>Employee Signature</b>	_____ <b>Date</b>	<b>Certified</b>	_____ <b>Employer Representative</b>	_____ <b>Date</b>
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## Dependent Dental Insurance

Effective	Name of Eligible Dependents to be Covered*	Date of Birth	Relationship

\*The term “dependent” is limited to the employee’s spouse, unmarried child to age 19, and unmarried children from 19 to 25 who are registered full-time students, principally dependent on the employee for maintenance and support, residing in the United States or Canada.

**If waiving coverage, please complete this section**

**I decline to enroll for dental insurance for the reason(s) indicated.** Please check appropriate box(es)

	<u><b>Covered under spouse</b></u>	<u><b>Other</b></u>
<input type="checkbox"/> Myself	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> My spouse	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> My dependent child(ren)	<input type="checkbox"/>	<input type="checkbox"/>

**EMPLOYEE STATEMENT - Waiving Coverage**

I hereby certify that I have been given an opportunity to request group dental coverage available to me and my dependents through my employer. I further understand that if I desire to participate in the Plan and do not make the required written application within thirty-one days of my eligibility date, the group dental benefits will be subject to a one-year waiting period which begins on the date I make written application.

_____ <b>Employee Signature</b>	_____ <b>Date</b>	<b>Certified</b>	_____ <b>Employer Representative</b>	_____ <b>Date</b>
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