Employers Dental Services

A company of the Principal Financial Group

EDS Dental Plan Enrollment & Change Form

PLEASE PRINT

Contract Number	Effective Date

☐ New Enrollment ☐ Change Address *(Complete Sections 1, 2, 3, 9)* ☐ Name Change *(Complete Sections 1, 2, 9)*

☐ Cancel Coverage ☐ Add Dependent(s) *(Complete Sections 1, 2, 9, 11)* Former Name: _____

☐ COBRA Enrollment ☐ Delete Dependent(s) *(Complete Sections 1, 2, 9, 11)* ☐ Change Dental Office *(Complete Sections 1, 2, 3, 4, 9)*

(1) Employer / Company Name Realty Executives - Group # 4361	Date Employed (mm/dd/yyyy)	(7) Home Telephone
(2) Your Name (Last, First, Middle Initial)		(8) Work Telephone
(3) Mailing Address, City	Zip Code	(9) Social Security #
(4) Dental Office Selection For You And Your Enrolled Dependents: 3-Digit Code Name of Office		(10) Date of Birth (mm/dd/yyyy)
(5) Do You Wish To Cover Your Eligible Dependents? ☐ Yes ☐ No	(6) Total No. Of Dependents To Enroll	Sex ☐ Male ☐ Female

(11) LIST ALL ELIGIBLE DEPENDENTS YOU WISH TO ENROLL: Attach additional cards if necessary

Last Name (if different)	First Name	Initial	Date of Birth
Spouse			
1. Child			
2. Child			
3. Child			
4. Child			

Eligibility: Eligible dependents will include lawful spouse and unmarried children to age 19, or any unmarried children to age 25, who attend an accredited educational institution on a full time basis and are fully dependent on employee for support or as stated in the employer's master contract. Participants may add dependents midyear if a marriage occurs. Participants may add dependents at date of employer group open enrollment. Dependent newborns or adopted children or children placed for adoption will be eligible immediately upon birth or upon adoption or placement for adoption. All newly eligible dependents must be added within 31 days of change. Dependent children must be deleted when they are no longer eligible.

Benefits are available at your selected contracted dental facility ONLY.

I hereby apply for coverage under EMPLOYERS DENTAL SERVICES for which I am now entitled or may become entitled under the provisions of the Master Agreement. I authorize deductions from my earnings at the required contributions towards the cost of the coverage. I certify that I am eligible to participate and that the above information is correct. I authorize any dentist or other dental care provider to furnish any representative of Employers Dental Services any and all records pertaining to dental history, services, or treatment of anyone enrolled for purposes of review, investigation, or evaluation of an application or claim. A photocopy of this authorization shall be valid as the original. This authorization shall remain valid for so long as my coverage remains in force. My authorized representative or myself are entitled to receive a copy of the authorizations form.

(Date)_____(Signature) _____