



Total Dental Administrators, Inc.

GROUP DENTAL ENROLLMENT FORM

New Employee
 Decline Coverage
 Change Coverage
 Transfer from DHMO
 Cancel Coverage

Name of Employer: (Use Name from Group Billing Notice or Master Application) Realty Execs	Group Number:	Div:	Class:
---	----------------------	-------------	---------------

Plan Types: <u>PLAN 1</u> <input type="checkbox"/> TDA-A500S HMO Dental Program	*Dental Office Selected* <u>PLAN 2</u> <input type="checkbox"/> "PPO" Indemnity Dental Program
--	---

<u>Social Security Number</u>	<u>Effective Date</u> Month / Day / Year	<u>Date Employed Full Time</u> Month / Day / Year	<u>Hours Worked</u> Per Week
Your Name (Last), (First) (MI)	Date of Birth Month / Day / Year		Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>

<u>Home Address:</u> _____ _____ Home Phone #: _____ Work Phone _____	<u>Coverage Requested:</u> <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + Child(ren) <input type="checkbox"/> Family
Do you have any other Dental Coverage? If so, Carrier _____	

Complete for Dependent Coverage: Spouse Name: (Last), (First) (MI)	Do any of your dependents have any other dental coverage?																																								
Sex:	If so, Name of Carrier:																																								
<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:5%; text-align: center;">C</td> <td style="width:5%;">1.</td> <td style="width:40%;"></td> <td style="width:15%; text-align: center;">Date of Birth</td> <td style="width:35%;"></td> </tr> <tr> <td style="text-align: center;">H</td> <td>2.</td> <td></td> <td style="text-align: center;">/ /</td> <td></td> </tr> <tr> <td style="text-align: center;">I</td> <td>3.</td> <td></td> <td style="text-align: center;">/ /</td> <td></td> </tr> <tr> <td style="text-align: center;">L</td> <td>4.</td> <td></td> <td style="text-align: center;">/ /</td> <td></td> </tr> <tr> <td style="text-align: center;">D</td> <td>5.</td> <td></td> <td style="text-align: center;">/ /</td> <td></td> </tr> <tr> <td style="text-align: center;">R</td> <td>6.</td> <td></td> <td style="text-align: center;">/ /</td> <td></td> </tr> <tr> <td style="text-align: center;">E</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td style="text-align: center;">N</td> <td></td> <td></td> <td></td> <td></td> </tr> </table>	C	1.		Date of Birth		H	2.		/ /		I	3.		/ /		L	4.		/ /		D	5.		/ /		R	6.		/ /		E					N					
C	1.		Date of Birth																																						
H	2.		/ /																																						
I	3.		/ /																																						
L	4.		/ /																																						
D	5.		/ /																																						
R	6.		/ /																																						
E																																									
N																																									

Fraud Warning (Not Applicable in AZ): 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 a fraudulent insurance act, which is a crime and subject such person to criminal and civil penalties.

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. I hereby apply for enrollment and agree to remain in the Plan a minimum of one year, authorize the release of any information relating to dental care received under the Plan, and to all terms and conditions set forth in the Group Agreement.

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** _____