Plans Administered by:
DENTCARE
DELIVERY SYSTEMS, INC.

Send Completed Form To:
[XXXXXXXXXX]
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Member Enrollment/Change Form

Application Type: ☐ New ☐ Change ☐ COBRA **Product:** ☐ PPO/EPO ☐ DHMO ☐ ASO ☐ Dual Option ☐ Other: _____

Plan Name: _____

Type of Activity

☐ New Enrollee	☐ Change	☐ COBRA
Effective Date _____	☐ Add Spouse _____	Qualifying Event _____
Group Name _____	☐ Add Child(ren) _____	Date of Event _____
Group Number _____	☐ Name Change _____	
	☐ Address Change _____	
	☐ Provider Change _____	

Eff. Date

Employee/Subscriber Information

Last Name	First Name	M.I.	SSN/ID #
Address	City	State	Zip Code
Home Phone	Email Address	Gender ☐M ☐F	D.O.B.

Marital Status
☐ Single ☐ Married ☐ Domestic Partner ☐ Divorced/Widow

Primary Care Dentist *(DHMO only) if no dentist is chosen, you will be assigned a PCD in your area.*

Dentist Name	Dentist Site Code

Spouse/Domestic Partner

Last Name, First Name	Gender ☐M ☐F	D.O.B.

Dependents To Be Covered

Last Name, First Name	Gender ☐M ☐F	D.O.B.

*Dependent eligibility is governed by your group's contract. If your dependent child is over your group's child dependent age limit and student verification is required, please submit student documentation.

Employee Signature

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for purpose of misleading, information concerning any fact thereto, commits a fraudulent insurance act, which is a crime, and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

Print Name	Signature	Date

Employee Verification

By signing, I affirm that the above-referenced employee is employed by the above-referenced employer/group.

Print Name	Signature	Title	Date