

# GROUP DENTAL ENROLLMENT FORM

<input type="checkbox"/> New Employee	<input type="checkbox"/> Add Coverage	<input type="checkbox"/> Add/Delete Dependent	<input type="checkbox"/> Decline Coverage	<input type="checkbox"/> Cancel Coverage
<input type="checkbox"/> Address/Name Change	<input type="checkbox"/> Loss of Other Coverage	<input type="checkbox"/> Transfer From DHMO	<input type="checkbox"/> Transfer From PPO	<input type="checkbox"/> COBRA Enrollment

<b>Name of Employer:</b> (Use Name from Group Billing Notice or Master Application) <div style="text-align: center; font-size: 1.2em;"><b>Uintah School District</b></div>	<b>Group Number:</b> <div style="text-align: center; font-size: 1.2em;"><b>V51 UTV54767</b></div>	<b>Class:</b>
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<b>Plan Types:</b>	
<input type="checkbox"/> <b>TDA-Companion</b>	<input type="checkbox"/> <b>EPO</b>

<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</u> (Last), (First), (MI)	<u>Date of Birth</u> Month / Day / Year	<b>Sex:</b> Male: <input type="checkbox"/> Female: <input type="checkbox"/>
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<u>Home Address:</u>  <u>Home Phone Number:</u> <u>Work Phone Number:</u>  Do you have any other Dental coverage? If so, Carrier _____	<b>Coverage Requested:</b> <input type="checkbox"/> Employee Only  <input type="checkbox"/> Employee + Spouse  <input type="checkbox"/> Employee + Children  <input type="checkbox"/> Employee + Family
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<b>Complete for Dependent Coverage:</b>			<b>Do any of your dependents have any other dental coverage?</b>	
<u>Spouse Name:</u> (Last), (First), (MI)	<u>Date of Birth:</u>			<b>If so, Name of Carrier:</b>
<b>Sex:</b>	/ /			
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
C H I L D R E N	1.	/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No
	2.	/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No
	3.	/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No
	4.	/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No
	5.	/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No
	6.	/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No

**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 subjects 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.

**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:** \_\_\_\_\_

Return To:  
**Total Dental Administrators, Inc.**  
 2111 East Highland Avenue, Suite 250  
 Phoenix, AZ 85016-4735  
 Fax - (602) 266-1948