



Group number: _____ Requested Effective Date: _____/_____/_____

Dental Application Form

Instructions: Please complete boxes outlined in **RED**.

A: Personal Information

Last Name: _____ Middle Initial: _____ First Name: _____
Date of Birth: ____/____/____ Social Security Number: _____
Street Address: _____ Apt #: _____
City: _____ State: _____ Zip Code: _____
Home Phone Number: _____ E-mail Address: _____
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Gender: ☐ Male ☐ Female Date of Hire: ____/____/____

B: Dependents to be Insured (Leave BLANK if coverage is NOT elected)

Dependent 1

Last Name: _____ Middle Initial: _____ First Name: _____
Date of Birth: ____/____/____ Social Security Number: _____
Gender: ☐ Male ☐ Female

Dependent 2

Last Name: _____ Middle Initial: _____ First Name: _____
Date of Birth: ____/____/____ Social Security Number: _____
Gender: ☐ Male ☐ Female

Dependent 3

Last Name: _____ Middle Initial: _____ First Name: _____
Date of Birth: ____/____/____ Social Security Number: _____
Gender: ☐ Male ☐ Female

Dependent 4

Last Name: _____ Middle Initial: _____ First Name: _____
Date of Birth: ____/____/____ Social Security Number: _____
Gender: ☐ Male ☐ Female

C: Prior Coverage

Did you have prior dental coverage? ☐ Yes ☐ No

If yes, please fill out the fields below:

Name of Previous Carrier: _____

Date of Termination: ____/____/____

Covered Individuals:

Last Name: _____ Middle Initial: ____ First Name: _____

Last Name: _____ Middle Initial: ____ First Name: _____

Last Name: _____ Middle Initial: ____ First Name: _____

Last Name: _____ Middle Initial: ____ First Name: _____

D: Acknowledgement of Coverage and Signature

Name Printed: _____

Signature Date: ____/____/____

Signature: **X** _____