Coverage - *Please verify with your employer which plans are available* .
Check all boxes that apply.

Employee	Dependents	*Coverage*
☐	☐	Dental
☐	☐	

Please print clearly when completing the Enrollment Form and return it to your Benefit Coordinator

Group/ Employer Name	Group No.	Effective Date	Date of Hire

Subscriber's Information

Last Name	First Name	MI	Subscriber SS#

Home Address	Apt. #

City	State	Zip

Male / Female	Date of Birth	Home Phone	Work Phone	Ext.

Dependent Information

Relationship	Last Name	First Name	MI	Male/ Female	Date of Birth

Other Coverage for All Enrolling Employees and Dependents

Do any persons on this application intend to continue other Group **Dental** coverage? ☐ Yes ☐ No

If yes, Name of person: ______________________________ Insurance Company: ______________

Waiver of Coverage

I have been given the opportunity to apply for group coverage, but:

☐ Do not choose to elect this coverage.
☐ Do not choose to elect coverage for my spouse.
☐ Do not choose to elect coverage for my child(ren)

Your Name (Please Print)	Your Signature	Date

BEL 9/06