



VERY IMPORTANT - Please Print Legibly

☐ New Enrollment
 ☐ Marital Status Change
 ☐ Terminate Enrollee Coverage
 ☐ SSN/Enrollee ID Number Correction or previous ID under which benefits are received

☐ Add/Delete Dependent
 ☐ Address Change
 ☐ Other _____

Social Security Number				Enrollee ID Number (if applicable)												Date of Birth			Gender ☐ Non-binary ☐ Male ☐ Female			Marital Status ☐ Single ☐ Married		
First Name				Last Name															Middle Initial					
Mailing Address (Street)												City						State			ZIP Code			
Email Address (internal use only)												Phone Number () -						Phone Type Cell ☐ Work ☐ Home ☐						
Name of Other Dental Carrier								Policy Holder Name (first/last)												Date of Birth / /				
Effective Date of Other Policy / /				Policy Holder Street Address								City						State			ZIP Code			

Group No.	Division	State
Effective Date / /	Hire Date / /	
Name of Employer		
Location	Pay Code	Benefit Package

☐ Full-Time ☐ Hourly ☐ Certified
☐ Part-Time ☐ Salaried ☐ Classified
☐ Retired ☐ Member/Other _____

- ☐ Termination
- ☐ Reduction in Hours
- ☐ Divorce/Legal Separation*
- ☐ Widowed/Surviving Dependent*
- ☐ Dependent Child No Longer Eligible*

Relationship	Dependent First Name (Last only if different from enrollee)	Add / Term	Social Security Number			Date of Birth		Non binary/ Male / Female	Student / Disabled**	Name of School (overage student)**
Spouse/Partner		☐ ☐						☐ ☐		
Dependent		☐ ☐						☐ ☐		
Dependent		☐ ☐						☐ ☐		
Dependent		☐ ☐						☐ ☐		
Dependent		☐ ☐						☐ ☐		

☐ I authorize any payroll deduction that may be required towards the cost of this coverage. I certify that the above information is true and correct to the best of my knowledge. I understand that changes can only be made if I experience a qualifying family status change, in which case the change must be consistent with that event, or as may otherwise be provided by the group contract.

Date / /