Dental Plan Enrollment Request

Dental Department
151 Farmington Avenue
Hartford, CT 06156-2001
1-800-253-1090

Office Use Only

Please read instructions on reverse side before completing this form. Print clearly.

1. Employer/Employee Information

Employer Name	Work Telephone Number ( )
Group Number	Effective Date of Coverage / /
Employee Name (Last, First, M.I.)	Social Security Number
Home Address - Street	Birthdate / /
City, State / ZIP Code	Home Telephone Number ( )

2. Type of Activity

☐ New Subscriber

☐ Add/Remove Spouse
Reason ____
Date of Event ____

☐ Add/Remove a Dependent Child
Reason ____
Date of Event ____

☐ Name Change from ____

☐ Add/Change Primary Dentist
(Fill in Numbers 3 and 4 below)

3.	No.	Add	Remove	Last Name, First Name, M.I.	Sex M	Sex F	Birthdate	Social Security No.
Employee	a.	☐	☐		☐	☐	/ /	
Spouse	b.	☐	☐		☐	☐	/ /	
Children	c.	☐	☐		☐	☐	/ /	
(Attach Sheet to List Additional Children)	d.	☐	☐		☐	☐	/ /	
	e.	☐	☐		☐	☐	/ /	
	f.	☐	☐		☐	☐	/ /	

4.	Change	Dentist Office Number
a.	☐	
b.	☐	
c.	☐	
d.	☐	
e.	☐	
f.	☐	

5. Other Insurance

Is your Spouse Employed? ☐ Yes ☐ No

If Yes, please give name and address of spouse's employer.

Does your Spouse have Dental Insurance? ☐ Yes ☐ No

If Yes, please give name and policy number of insurance carrier.

If Yes, who is covered by this policy?
☐ Yourself ☐ Yourself and Spouse ☐ Spouse Only ☐ Entire Family

6. Dependent Information

Do any of the dependents listed in Section 3 live at another address? ☐ Yes ☐ No

If Yes, who and at what address?

Explain the circumstances:

If any Dependent's last name is different from yours, explain the circumstances:

7. Employee Signature

I represent that all the information supplied in this application is true and complete. I hereby agree to the conditions of enrollment on the reverse side of the employee copy of the application.

Subscriber Signature ____ **Date** ____

*Employee copy may be used as a temporary ID card for 30 days from the effective date authorized by employer. Temporary ID's are only to be used for **Primary Dentist** visits.*

8. Employer Verification

Group Name	Group Number	Signature	Title	Effective Date of Coverage
				/ /