

Dentcare Enrollment Form

Last Name	First Name	M.I.	Social Security #
Address			Date of Birth
City	State	Zip Code	Home Telephone
Employer Name/Group	Group #		Office Telephone
Date of Hire: _____			
Gender: <input type="checkbox"/> M <input type="checkbox"/> F Coverage Selected: <input type="checkbox"/> Single <input type="checkbox"/> Husband & Wife / Parent & Child <input type="checkbox"/> Family / Parent & Children			
Other Dental Coverage: <input type="checkbox"/> No <input type="checkbox"/> Yes Name of Other Plan (if any): _____			

PLAN SELECTION: CapDent CapDent Advantage CapDent Advantage Plus

PRIMARY GENERAL DENTIST SELECTION (From CapDent Directory - One Per Family)

DENTIST NAME: _____ **DENTIST SITE CODE:** _____

DEPENDENTS TO BE COVERED (Spouse and unmarried dependent children)

Last Name	First Name	M.I.	M/F	Spse	Son	Dtr	Birth Date
							/ /
							/ /
							/ /
							/ /
							/ /
							/ /
							/ /

Agent Name (if applicable):

Agent Tax ID #:

I agree to maintain enrollment for a minimum of 12 months. If my coverage lapses for any reason, I understand that I cannot re-enroll for a twelve month period

SIGNATURE _____ **DATE** _____ **EFFECTIVE DATE** _____

Any person who includes any false or misleading information on an application for an Insurance Policy is subject to criminal and civil penalties.

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