GROUP USE ONLY

(Please Print)

Last Name of Applicant	First Name	Middle Initial	Phone No.	Male ☐ Female ☐	Married ☐ Single ☐
Street Address	City	State & ZIP		Date of Birth: Month Day Year	
Name of Employer			Date of Employment	Social Security Number	

Effective Date

Group Number

DEPENDENT INFORMATION — List Spouse and Unmarried Children

Name of Dependent	Relationship	Date of Birth	Name of Dependent	Relationship	Date of Birth

FROM THE LIST OF PARTICIPATING PROVIDERS, SELECT A DENTAL OFFICE TO BE YOUR PRIMARY DENTAL CARE PROVIDER AND ENTER THE NAME BELOW.

Name of Provider Office

I hereby represent to you that all information furnished by me on this application is true and complete to the best of my knowledge.

Signature of Applicant

Date Signed