



**Employers  
Dental  
Services**

Contract Number  
\_\_\_\_\_

- New Enrollment
- Change of Family Status (Complete Sections 1, 2, 9, 11, 12)
- Change of Address or Phone Number

- COBRA
- Cancel

Effective Date  
\_\_\_\_\_

(1) Employer _____	Date Employed (mm/dd/yyyy) _____	Sex <input type="checkbox"/> M <input type="checkbox"/> F	(7) Home Telephone _____
(2) Your Name (Last, First, Middle Initial) _____			(8) Work Telephone _____
(3) Mailing Address, City _____		Zip Code _____	(9) Social Security # _____
(4) Dental Office Selection For You And Your Enrolled Dependants: _____	(5) Do You Wish To Cover Your Eligible dependents? <input type="checkbox"/> Yes <input type="checkbox"/> No	(6) Total No. of Dependents _____	(10) Date of Birth (mm/dd/yyyy) _____

(11) LIST ALL ELIGIBLE DEPENDENTS YOU WISH TO COVER: Attach additional cards if necessary

Last Name (if different)	First Name	Initial	Date of Birth
Spouse _____			
1. Child _____			
2. Child _____			
3. Child _____			

**Eligibility:** Eligible dependents will include lawful spouse and unmarried children to age 19, or any unmarried children to age 25, who attend an accredited educational institution on a full time basis and are fully dependent on employee for support or as stated in the employer's master contract. Participants may add dependents midyear if a marriage occurs. Participants may add dependents at date of employer group open enrollment. Dependent newborns or adopted children or children placed for adoption will be eligible immediately upon birth or upon adoption or placement for adoption. All newly eligible dependents must be added within 31 days of change. Dependent children must be deleted when they are no longer eligible.

**Benefits are available at your selected contracted dental facility ONLY.**

(12) **Change of Status Only** Please change my enrollment as follows:  
 Change name to that shown above. Former Name \_\_\_\_\_  
 Delete dependents shown above.  
 Add dependents shown above. Date of Marriage \_\_\_\_\_

I hereby apply for coverage under EMPLOYERS DENTAL SERVICES for which I am now entitled or may become entitled under the provisions of the Master Agreement. I authorize deductions from my earnings at the required contributions towards the cost of the coverage. I certify that I am eligible to participate and that the above information is correct. I authorize any dentist or other dental care provider to furnish any representative of Employers Dental Services any and all records pertaining to dental history, services, or treatment of anyone enrolled for purposes of review, investigation, or evaluation of an application or claim. A photocopy of this authorization shall be valid as the original. This authorization shall remain valid for so long as my coverage remains in force. My authorized representative or myself are entitled to receive a copy of the authorizations form.

(Date) \_\_\_\_\_ (Signature) \_\_\_\_\_