



GROUP DENTAL ENROLLMENT FORM

UTAH

TOTAL DENTAL ADMINISTRATORS, INC.

<input type="checkbox"/> New Employee	<input type="checkbox"/> Add Coverage	<input type="checkbox"/> Change Dependent	<input type="checkbox"/> Address Change	<input type="checkbox"/> Cancel Coverage
---------------------------------------	---------------------------------------	---	---	--

Name of School:	Alpine Carbon Nebo Provo (Please circle district)
------------------------	--

TDA-COMPANION	Elite Choice	TC-6000 PLAN	DENTAL ECLIPSE
<input type="checkbox"/> Single \$36.53	<input type="checkbox"/> Single \$25.38	<input type="checkbox"/> Single \$13.28	<input type="checkbox"/> Single \$3.00
<input type="checkbox"/> Two-Party \$75.64	<input type="checkbox"/> Two-Party \$49.73	<input type="checkbox"/> Two-Party \$26.54	<input type="checkbox"/> Two-Party \$5.00
<input type="checkbox"/> Family \$122.99	<input type="checkbox"/> Family \$80.96	<input type="checkbox"/> Family \$43.88	<input type="checkbox"/> Family \$5.00
		<small>*Dental Office Selected* # _____</small>	<small>*Dental Office Selected* # _____</small>

<u>Social Security Number</u>	<u>Effective Date</u> Month / Day / Year	<u>Date Employed Fulltime</u> Month / Day / Year	<u>Hours Worked Per Week</u>
--------------------------------------	--	--	-------------------------------------

Your Name (Last), _____ (First), _____ (MI) _____	<u>Date of Birth</u> Month / Day / Year	Sex: Male: <input type="checkbox"/> Female: <input type="checkbox"/>
--	---	---

<u>Home Address:</u>	<u>Home Phone Number:</u>
	<u>Work Phone Number:</u>
	<u>Email Address:</u>
Do you have any other Dental coverage? If so, Carrier _____	

Complete for Dependent Coverage:		Do any of your dependents have any other dental coverage?	
Spouse Name: (Last), _____ (First), _____ (MI) _____	Date of Birth:		If so, Name of Carrier:
Sex:	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	
C H I L D R E N	1. /	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No
	2. /	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No
	3. /	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No
	4. /	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No
	5. /	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No
	6. /	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No

Fraud Warning (Not Applicable in AZ): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

I elect the dental coverage selected for which I am eligible. If any contribution from me is necessary to pay part of the cost of insurance. I authorize my employer to deduct the contribution from my wages.

Date	Employee Signature: _____
Refusal of Group Dental Coverage: I have been offered this insurance coverage and decline to purchase it at this time. I understand that in the event I desire such insurance at a later date, I will be required to furnish evidence of insurability at my own expense, and the company will have the right to refuse any request.	
Date	Employee Signature: _____

For Personnel Use Only	
Approved By: _____	Effective Date: _____

Return To:
Bonneville Uniserv (801) 224-2055
 39 South 400 West, Orem, Utah 84058