



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
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Name of School:	CARBON
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TDA-COMPANION <input type="checkbox"/> Single \$37.99 <input type="checkbox"/> Two-Party \$78.67 <input type="checkbox"/> Family \$127.91	TDA-PPO/MAC <input type="checkbox"/> Single \$31.42 <input type="checkbox"/> Two-Party \$65.05 <input type="checkbox"/> Family \$105.77	Elite Choice <input type="checkbox"/> Single \$26.40 <input type="checkbox"/> Two-Party \$51.72 <input type="checkbox"/> Family \$84.20	Premium High DHMO <input type="checkbox"/> Single \$12.32 <input type="checkbox"/> Two-Party \$25.56 <input type="checkbox"/> Family \$38.98 <small>*Dental Office Selected* # _____</small>
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Social Security Number	Effective Date <small>Month / Day / Year</small>	Date Employed Fulltime <small>Month / Day / Year</small>	Hours Worked Per Week
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Your Name (Last), _____ (First), _____ (MI) _____	Date of Birth <small>Month / Day / Year</small>	Sex: Male: <input type="checkbox"/> Female: <input type="checkbox"/>
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Home Address: _____	Home Phone Number: _____
	Work Phone Number: _____

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

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:** _____