



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

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