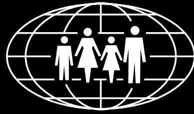

Employee Enrollment Form

7400 York Road • Towson, MD 21204
Tel: (410) 847-9060 / Fax: (410) 847-9062
Toll Free: 1-888-833-8464

1. Subscriber Information

Last Name	First Name	MI	Social Security Number – –
Street Address		Apt. No.	Employment Date / /
City	State	Zip	Employment Status ❏ Active ❏ Retired
Sex	Date of Birth / /	Home Phone Number ( )	Business Phone Number Ext. ( )
Name of Employer		Department	

2. Coverage Selection

❏ Individual ❏ Parent / Child ❏ Husband / Wife ❏ Family

3. Dependent Information

4. Dental Office Selected*

Last Name First Name MI	Social Security No.	Relationship	Date of Birth	Please Indicate Dental Office for each Member	Dentist Provider #
		Self			
		Spouse			
		❏ Daughter ❏ Son			
		❏ Daughter ❏ Son			
		❏ Daughter ❏ Son			
		Other			

* Dental Office Must Be Selected In Order for Policy to Become Effective

5. Additional Dependent Information

Are any of your dependents covered by Medicare? ❏ Yes ❏ No Dependent Name ________________

Are any of your dependents disabled? Effective date of disability
1. Name ________________ ________________
2. Name ________________ ________________

Full Time (19 or over) Students?
1. Name ________________ School Name ________________ Exp. Grad. Date ________
2. Name ________________ School Name ________________ Exp. Grad. Date ________

I hereby agree to remain in the Plan a minimum of one (1) year. Less than a one-year membership may result in my being billed Normal and Customary Fees, less Cost for Services and Covered Employee Additional Charges paid, as those terms are defined in the Certificate of Coverage.

Signature: ________________ Date: ________________

For Office use only

Effective Date:	Department:	Plan #:
Group No.:	Approved By:	Rate:

FORM DN006 REVISED (10/98)