DENTCARE
DELIVERY SYSTEMS, INC.

MANAGED CARE ENROLLMENT FORM

Employer Information

Employer's Name			
Group Number	Effective Date		

Member Information

Last Name	First Name	M.I.	SSN/ID #	
Address	City	State	Zip Code	
Home Phone				

Other Dental Coverage Yes ☐ No ☐	Name of other plan (if applicable)

Marital Status

☐ Single ☐ Domestic Partners ☐ Married ☐ Divorced/Widow

Dependents To Be Covered - Spouse, Domestic Partner & Unmarried Dependent Children. Dependent eligibility is governed by your group's contract - if child is over age 18 and student verification is required for your group, please attach documentation.

		Check Appropriate Box			
Last Name, First Name	M/F	Spouse/D.P.	Son	Dtr	D.O.B.
Last Name, First Name	M/F	Spouse/D.P.	Son	Dtr	D.O.B.
Last Name, First Name	M/F	Spouse/D.P.	Son	Dtr	D.O.B.
Last Name, First Name	M/F	Spouse/D.P.	Son	Dtr	D.O.B.
Last Name, First Name	M/F	Spouse/D.P.	Son	Dtr	D.O.B.
Last Name, First Name	M/F	Spouse/D.P.	Son	Dtr	D.O.B.
Last Name, First Name	M/F	Spouse/D.P.	Son	Dtr	D.O.B.

Dental Selection - Please choose one Primary Care Dentist from the Dentcare Comprehensive Directory - One Per Family

Dentist Name	Dentist Site Code

I agree to abide by the terms and conditions of the contract.

Signature	Date

Any person who includes any false or misleading information on an application for an Insurance Policy is subject to criminal and civil penalties.

"PLEASE PRINT OR TYPE ALL INFORMATION"

Dentcare Delivery Systems, Inc.

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