

<b>Employer Information</b>						
Employer's Name						
Group Number			Effective Date			
<b>Member Information</b>						
Last Name		First Name		M.I.	SSN/ID #	
Address			City	State	Zip Code	
Home Phone						
Other Dental Coverage Yes <input type="checkbox"/> No <input type="checkbox"/>	Name of other plan (if applicable)					
<b>Marital Status</b>						
<input type="checkbox"/> Single	<input type="checkbox"/> Domestic Partners	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced/Widow			
<b>Dependents To Be Covered - Spouse, Domestic Partner &amp; 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.</b>						
		<b>Check Appropriate Box</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.
Last Name, First Name		M/F	Spouse/D.P.	Son	Dtr	D.O.B.
<b>Dental Selection - Please choose one Primary Care Dentist from the Dentcare Comprehensive Directory - One Per Family</b>						
Dentist Name			Dentist Site Code			
<b>I agree to abide by the terms and conditions of the contract.</b>						
Signature			Date			
<b>Any person who includes any false or misleading information on an application for an Insurance Policy is subject to criminal and civil penalties.</b>						

**"PLEASE PRINT OR TYPE ALL INFORMATION"**

### Dentcare Delivery Systems, Inc.

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