

Dental Enrollment Form

Group Dental Coverage Underwritten by
Standard Life & Accident Insurance Company

CAREINGTON (EXTENDED) PPO Dental Plans

SOCIAL SECURITY NUMBER	EMPLOYEE ID NUMBER (if different than SSN)	<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change <input type="checkbox"/> Waiver		
		DATE : / /		
LAST NAME		FIRST NAME		MI
ADDRESS		CITY	STATE	ZIP
TELEPHONE NUMBER				<input type="checkbox"/> Male <input type="checkbox"/> Female
HOME ()		WORK ()		<input type="checkbox"/> Single <input type="checkbox"/> Married
APPLICANTS DATE OF BIRTH	EMPLOYER OR GROUP NAME			
PLAN DESIGN <input type="checkbox"/> X1 <input type="checkbox"/> X2 <input type="checkbox"/> X3		Effective Date: / /		
PLAN COVERAGE		<input type="checkbox"/> Employee <input type="checkbox"/> Employee + One <input type="checkbox"/> Family		

INFORMATION FOR DEPENDENT COVERAGE

Spouse & Unmarried Dependent Children Only (Include Date of Birth)

First Name Initial Last Name (if different)	Date of Birth (Mo/Day/Yr)	Relationship			If Child is over 19, please indicate status and school	
		<input type="checkbox"/> Wife	<input type="checkbox"/> Husband	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Student at: _____ <input type="checkbox"/> Handicapped	<input type="checkbox"/> Enroll <input type="checkbox"/> Change <input type="checkbox"/> Cancel
		<input type="checkbox"/> Son	<input type="checkbox"/> Daughter	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Student at: _____ <input type="checkbox"/> Handicapped	<input type="checkbox"/> Enroll <input type="checkbox"/> Change <input type="checkbox"/> Cancel
		<input type="checkbox"/> Son	<input type="checkbox"/> Daughter	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Student at: _____ <input type="checkbox"/> Handicapped	<input type="checkbox"/> Enroll <input type="checkbox"/> Change <input type="checkbox"/> Cancel
		<input type="checkbox"/> Son	<input type="checkbox"/> Daughter	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Student at: _____ <input type="checkbox"/> Handicapped	<input type="checkbox"/> Enroll <input type="checkbox"/> Change <input type="checkbox"/> Cancel
		<input type="checkbox"/> Son	<input type="checkbox"/> Daughter	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Student at: _____ <input type="checkbox"/> Handicapped	<input type="checkbox"/> Enroll <input type="checkbox"/> Change <input type="checkbox"/> Cancel

*For court ordered dependent, legal documentation must be attached. Please see employer representative for more information about the qualifications for full-time student status. If dependent does not reside with eligible employee, please provide address on separate sheet.

FOR INTERNAL USE ONLY

EMPLOYER or GROUP AUTHORIZATION
EFFECTIVE DATE
TYPE OF COVERAGE

SIGNATURE _____
I hereby understand that any coverage is limited by the benefits and exclusions of the Group Dental Agreement

MINIMUM ENROLLMENT IS FOR ONE YEAR

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