TDA
Total Dental Administrators

GROUP DENTAL ENROLLMENT FORM

☐ New Employee	☐ Add Coverage	☐ Add/Delete Dependent	☐ Decline Coverage	☐ Cancel Coverage
☐ Address/Name Change	☐ Loss of Other Coverage	☐ Transfer From DHMO	☐ Transfer From PPO	☐ COBRA Enrollment

Name of Employer: (Use Name from Group Billing Notice or Master Application)	Group Number:	Class:

Plan Types:

☐

Social Security Number	**Effective Date** Month / Day / Year	**Date Employed Fulltime** Month / Day / Year	**Hours Worked Per Week**

Your Name (Last), (First), (MI)	**Date of Birth** Month / Day / Year	**Sex:** Male: ☐ Female: ☐

Home Address:

Home Phone Number: Work Phone Number:

Do you have any other Dental coverage? If so, Carrier_____.

Coverage Requested:

☐ **Employee Only**

☐ **Employee + 1**

☐ **Employee + Family**

Complete for Dependent Coverage:

	Spouse Name: (Last), (First), (MI) / **Sex:**	**Date of Birth:**	**Do any of your dependents have any other dental coverage?**	**If so, Name of Carrier:**
		/ /	☐ Yes ☐ No	
CHILDREN	**1.** /	/ /	☐ Yes ☐ No	
	2. /	/ /	☐ Yes ☐ No	
	3. /	/ /	☐ Yes ☐ No	
	4. /	/ /	☐ Yes ☐ No	
	5. /	/ /	☐ Yes ☐ No	
	6. /	/ /	☐ Yes ☐ 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:**

Return To:
Total Dental Administrators, Inc.
2111 East Highland Avenue, Suite 250
Phoenix, AZ 85016-4735
1-888-422-1995