

GROUP DENTAL ENROLLMENT FORM

<input type="checkbox"/> New Employee	<input type="checkbox"/> Add Coverage	<input type="checkbox"/> Change Dependent	<input type="checkbox"/> Address Change	<input type="checkbox"/> Cancel Coverage
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Name of Employer: (Use Name from Group Billing Notice or Master Application)	Group Number:	Div:	Class:
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Plan Types:

<u>Social Security Number</u>	<u>Effective Date</u> Month / Day / Year	<u>Date Employed Fulltime</u> Month / Day / Year	<u>Hours Worked Per Week</u>
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Your Name (Last), (First), (MI)	<u>Date of Birth</u> Month / Day / Year	Sex: Male: <input type="checkbox"/> Female: <input type="checkbox"/>
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Home Address: Home Phone Number: Work Phone Number:	Coverage Requested: <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + 1 <input type="checkbox"/> Employee + Family
Do you have any other Dental coverage? If so, Carrier: _____	

Complete for Dependent Coverage:			Do any of your dependents have any other dental coverage?	
<u>Spouse Name:</u> (Last), (First), (MI)	<u>Date of Birth:</u>			<u>If so, Name of Carrier:</u>
Sex:	/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	
CHILDREN	1.	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	2.	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	3.	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	4.	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	5.	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	6.	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> 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: _____

Underwritten by: COMPANION LIFE INSURANCE COMPANY
Columbia, South Carolina

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

1/1/2006