DENTAL Enrollment/Change Form

PALM TRAN RETIREE

Employer Only Section

Coverage Effective Date: / /

Approved/Processed By: _____

Check ALL the Appropriate Boxes

☐ New Enroll ☐ Annual Open Enroll ☐ Change ☐ Cancel

Reason & Event:	☐ Cancel Coverage ☐ Other Insurance ☐ Other _____ Last Date of Coverage: _____	☐ Add Dependent ☐ Marriage ☐ Birth ☐ Adoption/Custody ☐ Court ordered ☐ Other: _____ Begin date of coverage: _____	☐ Cancel Retiree or Dependent ☐ Divorce ☐ Death ☐ Dependent married/reached age limit ☐ Other: _____ Date of Event: _____

Retiree Information

Social Security Number: - -	Date of Birth: / /	Sex: ☐ Male ☐ Female
Last Name:	First Name:	Middle Initial:
Address:		
City:	State:	Zip Code:
Home Phone:	Day Time Phone:	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Product Selection

Plan Coverage: ☐ Retiree Only ☐ Retiree + 1 ☐ Retiree + 2 ☐ Retiree + 3 or more ☐ Spouse Only

Please indicate your Plan selection: ☐ DHMO ☐ Low PPO ☐ High PPO ☐ Decline Coverage

Family Information

Marriage/birth certificates will be required to add spouse/child
Social Security number is required for all dependents (no exceptions)

List dependents to be enrolled, cancelled, changed: (Attach additional sheet if necessary)

Check Appropriate Box	First Name MI Last Name (if different) Dependent Social Security Number	Date of Birth	Sex	Relationship**
☐ Enroll ☐ Change ☐ Cancel	SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___	/ /	☐ M ☐ F	☐ Spouse ☐ Domestic Partner*
☐ Enroll ☐ Change ☐ Cancel	SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___	/ /	☐ M ☐ F	☐ Son ☐ Daughter ☐ Other:
☐ Enroll ☐ Change ☐ Cancel	SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___ SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___	/ /	☐ M ☐ F	☐ Son ☐ Daughter ☐ Other:

Employee/Applicant Signature: (form must be signed) Date: / /

I hereby declare that all the statements made above are, to the best of my knowledge and belief, true and complete and that they are the basis on which insurance requested by me may be issued.
I understand that the dental benefit plan I have selected provides reimbursement for certain dental costs which are more fully described in the current Certificate of Coverage. I understand there may be instances where treatment decisions made by my Dentist or me for dental expenses which I have incurred may not be covered by my dental benefit plan. **The Certificate provides dental benefits only. Review your Certificate carefully.**

FRAUD WARNING NOTICE{S}: {(Please review the notice that applies in your state.)}

{For applicants in Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.}