

COMPLETE ALL NON-SHADED AREAS, SIGN AND DATE. PLEASE PRINT OR TYPE.

EMPLOYEE										SOCIAL SECURITY NUMBER																																																	
LAST NAME					FIRST					INITIAL					DATE OF BIRTH					SEX																																							
															MO					DAY					YR					M					F																								
STREET ADDRESS															APT#															HOME PHONE																													
CITY															STATE															ZIP															WORK PHONE														
DATE EMPLOYED										EMPLOYER (GROUP)										GROUP #										CHOOSE DENTAL OFFICE																													
LIST ALL DEPENDENTS TO BE COVERED BELOW															DATE OF BIRTH																														SEX														
LAST NAME					FIRST					INITIAL					MO					DAY					YR					M					F					Write dentist name and number from list.																			
SPOUSE																																													# OF DEPENDENTS COVERED														
CHILD 1																																																											
CHILD 2																																																											
CHILD 3																																																											
CHILD 4																																																											
CHILD 5																																																											
EFFECTIVE DATE - 1ST OF THE MONTH										PREMIUM AMOUNT										AMOUNT PAID										PLAN #										AGENT #																			

I hereby authorize the Group to deduct monthly for 12 months, and future renewal period(s) my portion of such subscription fee from any funds due me. I understand that enrollments are by Group contract and/or for consecutive 12 month period(s) and my subscription fee is subject to change on the anniversary date of the Group. I hereby represent to the carrier that all information furnished by me hereon is true and complete to the best of my knowledge.

I hereby consent, personally and on behalf of any family member enrolled, to the unrestricted release of my/our dental records maintained by participating dentists to Company for, but not limited to, claims verification and quality assessment review, and to any other participating dentist who may be or become involved in my/our dental care.

X _____
Signature

X _____
Date

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. You may cancel this contract within 30 days of coverage effective date.

This is a CompBenefits Benefit Plan.

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