



GROUP USE ONLY

(Please Print)

Last Name of Applicant		First Name	Middle Initial	Phone No.	Male ☐	Married ☐	Effective Date		
					Female ☐	Single ☐			
Street Address		City	State & ZIP		Date of Birth	Month	Day	Year	Group Number
Name of Employer		Date of Employment		Social Security Number					

DEPENDENT INFORMATION — List Spouse and Unmarried Children

Name of Dependent	Relationship	Date of Birth	Name of Dependent	Relationship	Date of Birth

FROM THE LIST OF PARTICIPATING PROVIDERS,
SELECT A DENTAL OFFICE TO BE YOUR
PRIMARY DENTAL CARE PROVIDER AND ENTER
THE NAME BELOW.

Name of Provider Office

I hereby represent to you that all information furnished by me on this application is true and complete to the best of my knowledge.

Signature of Applicant

Date Signed