



**INFORCE CHANGES-EMPLOYER ONLY**

Group No. \_\_\_\_\_  New Hire  
 Req. Eff. Date \_\_\_\_\_  Open Enrollment



(800) 782-7907

**VOLUNTARY DENTAL ENROLLMENT**

(Please Print - Use ballpoint pen and press firmly)

Employer Name <b>Federal Employees</b>	Location/Division	Date of Hire
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Employee Name	Sex	Social Security No. / /	Date of Birth
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Home Address	City	State	Zip	Work Phone ( )
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<b>Coverage Applied For:</b> <input type="checkbox"/> Employee <input type="checkbox"/> Child(ren) <input type="checkbox"/> Spouse      (If elected, all eligible children must be enrolled)	<b>Decline Coverage For:</b> <input type="checkbox"/> Employee <input type="checkbox"/> Child(ren) <input type="checkbox"/> Spouse	<b>Plan</b>
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	Name	Sex	Date of Birth (mo/day/yr)	Full-Time Student	
				Yes	No
Spouse					
Child				<input type="checkbox"/>	<input type="checkbox"/>
Child				<input type="checkbox"/>	<input type="checkbox"/>
Child				<input type="checkbox"/>	<input type="checkbox"/>
Child				<input type="checkbox"/>	<input type="checkbox"/>

I request insurance under my employer's insurance plan as it is now or as it may be amended in the future. I represent, to the best of my knowledge and belief that all statements and answers made in this enrollment are complete and true. If such insurance becomes effective, I authorize deductions from my earnings; the amount necessary to pay any premiums due or past due. I further authorize to make any necessary changes and adjustments in said deductions as may be necessary from time to time due to changes in rates. In the event the policy cannot be issued, the company agrees this authorization will be void.

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 Employee Signature Date