



Male <input type="checkbox"/>	Married <input type="checkbox"/>
Female <input type="checkbox"/>	Single <input type="checkbox"/>
Date of Birth	Month Day Year
Social Security Number	
SPONSORED DEPENDENT (Separate Application Necessary)	
Name	
Date of Birth	Month Day Year

GROUP USE ONLY

(Please Print)

Last Name of Applicant	First Name	Middle Initial	Phone No.
Street Address		City	State & Zip
Name of Employer		Date of Employment	

Effective Date

Effective Date

Group Number

DEPENDENT INFORMATION — List Spouse and Unmarried Children Under 19 Years of Age. Full-time Students Under 23.

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

