



# GROUP DENTAL ENROLLMENT FORM

# TOTAL DENTAL ADMINISTRATORS, INC.

<input type="checkbox"/> New Employee	<input type="checkbox"/> Add Coverage	<input type="checkbox"/> Add/Delete Dependent	<input type="checkbox"/> Decline Coverage	<input type="checkbox"/> Cancel Coverage
<input type="checkbox"/> Address/Name Change	<input type="checkbox"/> Loss of Other Coverage	<input type="checkbox"/> Transfer From DHMO	<input type="checkbox"/> Transfer From PPO	<input type="checkbox"/> COBRA Enrollment

<b>Name of School:</b>	<b>District:</b> <b>Alpine School District</b>
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<b>Peak Care Plus (formally DHMO)</b> <input type="checkbox"/> Single <b>\$12.96</b> <input type="checkbox"/> Two-Party <b>\$26.90</b> <input type="checkbox"/> Family <b>\$42.19</b> *Dental Office Selected* # _____	<b>Elite Choice</b> <input type="checkbox"/> Single <b>\$27.74</b> <input type="checkbox"/> Two-Party <b>\$57.79</b> <input type="checkbox"/> Family <b>\$95.41</b>	<b>TDA PPO/MAC</b> <input type="checkbox"/> Single <b>\$34.50</b> <input type="checkbox"/> Two-Party <b>\$77.78</b> <input type="checkbox"/> Family <b>\$131.29</b>	<b>TDA Companion</b> <input type="checkbox"/> Single <b>\$38.75</b> <input type="checkbox"/> Two-Party <b>\$83.29</b> <input type="checkbox"/> Family <b>\$137.35</b>
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<b>Social Security Number</b>	<b>Effective Date</b> Month / Day / Year	<b>Date Employed Fulltime</b> Month / Day / Year	<b>Hours Worked Per Week</b>
<b>Your Name</b> (Last), _____ (First), _____ (MI)	<b>Date of Birth</b> Month / Day / Year		<b>Sex:</b> Male: <input type="checkbox"/> Female: <input type="checkbox"/>

<b>Home Address:</b>	<b>Home Phone Number:</b>
	<b>Work Phone Number:</b>
	<b>Email Address:</b>
Do you have any other Dental coverage? If so, Carrier _____	

<b>Complete for Dependent Coverage:</b>			<b>Do any of your dependents have any other dental coverage?</b>	
<b>Spouse Name:</b> (Last), _____ (First), _____ (MI)		<b>Date of Birth:</b>	<b>If so, Name of Carrier:</b>	
<b>Sex:</b>		/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	
DEPENDENT	1.	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	2.	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	3.	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	4.	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	5.	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	6.	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	

**Fraud Warning** (Not Applicable in AZ): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

I elect the dental coverage selected for which I am eligible. If any contribution from me is necessary to pay part of the cost of insurance. I authorize my employer to deduct the contribution from my wages.

**Date** \_\_\_\_\_ **Employee Signature:** \_\_\_\_\_

**Refusal of Group Dental Coverage:** I have been offered this insurance coverage and decline to purchase it at this time. I understand that in the event I desire such insurance at a later date, I will be required to furnish evidence of insurability at my own expense, and the company will have the right to refuse any request.

**Date** \_\_\_\_\_ **Employee Signature:** \_\_\_\_\_

**For Personnel Use Only**  
**Approved By:** \_\_\_\_\_ **Effective Date:** \_\_\_\_\_

Return To: