GROUP DENTAL ENROLLMENT FORM

TOTAL DENTAL ADMINISTRATORS, INC.

☐ New Employee	☐ Add Coverage	☐ Add/Delete Dependent	☐ Decline Coverage	☐ Cancel Coverage
☐ Address/Name Change	☐ Loss of Other Coverage	☐ Transfer From DHMO	☐ Transfer From PPO	☐ COBRA Enrollment

Name of School:	**District:** **Alpine School District**

Premium High DHMO		**Elite Choice**		**TDA PPO/MAC**		**TDA Companion**	
☐ Single	**$12.71**	☐ Single	**$27.74**	☐ Single	**$33.99**	☐ Single	**$38.75**
☐ Two-Party	**$26.37**	☐ Two-Party	**$57.79**	☐ Two-Party	**$74.25**	☐ Two-Party	**$83.29**
☐ Family	**$41.36**	☐ Family	**$95.41**	☐ Family	**$123.23**	☐ Family	**$137.35**
						Dental Office Selected #____________	

Social Security Number	**Effective Date** Month / Day / Year	**Date Employed Fulltime** Month / Day / Year	**Hours Worked Per Week**
Your Name (Last), (First), (MI)		**Date of Birth** Month / Day / Year	**Sex:** Male: ☐ Female: ☐

Home Address:	**Home Phone Number:**
	Work Phone Number:
Do you have any other Dental coverage? If so, Carrier	**Email Address:**

Complete for Dependent Coverage:			**Do any of your dependents have any other dental coverage?**	**If so, Name of Carrier:**
Spouse Name: (Last), (First), (MI)	**Sex:**	**Date of Birth:** / /	☐ **Yes** ☐ **No**	
CHILDREN 1.	/	/ /	☐ **Yes** ☐ **No**	
2.	/	/ /	☐ **Yes** ☐ **No**	
3.	/	/ /	☐ **Yes** ☐ **No**	
4.	/	/ /	☐ **Yes** ☐ **No**	
5.	/	/ /	☐ **Yes** ☐ **No**	
6.	/	/ /	☐ **Yes** ☐ **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:

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