2019-2020

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

Peak Care Plus (formally DHMO)		Elite Choice		TDA PPO/MAC		TDA Companion	
☐ Single	$13.22	☐ Single	$27.88	☐ Single	$34.76	☐ Single	$39.14
☐ Two-Party	$27.44	☐ Two-Party	$58.08	☐ Two-Party	$78.36	☐ Two-Party	$84.12
☐ Family	$43.03	☐ Family	$95.89	☐ Family	$132.27	☐ Family	$138.72
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:

	Name	Sex:	Date of Birth:	Do any of your dependents have any other dental coverage?	If so, Name of Carrier:
Spouse Name:	(Last), (First), (MI)		/ /	☐ 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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