2020-2021

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

Social Security Number	**Effective Date** Month / Day / Year	**Date Employed Fulltime** Month / Day / Year	**Hours Worked Per Week**

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 #			

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:

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

Voice: 801-224-2055 x2
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FAX: 801-224-6137

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