



# GROUP DENTAL ENROLLMENT FORM

2022-2023

**RETIREE**

# 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> Alpine School District
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<u>Social Security Number</u>	<u>Effective Date</u> Month / Day / Year	<u>Date Employed Fulltime</u> Month / Day / Year	<u>Hours Worked Per Week</u>
<b>Peak Care Plus (formally DHMO)</b>	<b>Elite Choice</b>	<b>TDA PPO/MAC</b>	<b>TDA Companion</b>
<input type="checkbox"/> Single     \$13.75	<input type="checkbox"/> Single     \$28.44	<input type="checkbox"/> Single     \$36.15	<input type="checkbox"/> Single     \$39.92
<input type="checkbox"/> Two-Party   \$28.55	<input type="checkbox"/> Two-Party   \$59.24	<input type="checkbox"/> Two-Party   \$81.49	<input type="checkbox"/> Two-Party   \$85.80
<input type="checkbox"/> Family       \$44.77	<input type="checkbox"/> Family       \$97.81	<input type="checkbox"/> Family       \$137.56	<input type="checkbox"/> Family       \$141.49
*Dental Office Selected* # _____			

<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"/>
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<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	
CHILDREN	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:** \_\_\_\_\_

# TDA RETIREE ENROLLMENT FORM

## ATOMATIC CHECKING INSTRUCTIONS

1. Complete the TDA Dental Application. Be sure to list your dependent names and birth dates if you are applying for a 2 party or Family Dental Plan.
2. Complete the Direct Monthly Payment Authorization below! Be sure to include a **VOIDED Check!**
3. Premium statements are run on the 15<sup>th</sup> of each month. ACH transactions are processed on the 20<sup>th</sup> of each month for the Grand Total Due. Any adjustments (adds, term, changes) will appear on the next billing cycle.
4. Make Check payable to TDA – for the first months premium if it is after the bill date of the 15<sup>th</sup> of the month.

MAIL, SCAN OR DROP BY THE COMPLETED APPLICATION TO:

Alpine Uniserv Attention: Annie

Mail: 557 West Center Street, Pleasant Grove Utah 84062

Scan/E-mail: [annie@alpineuniserv.org](mailto:annie@alpineuniserv.org)

**Any questions please call: Annie at (801) 224-2055 ext. 2**

### DIRECT MONTHLY PAYMENT AUTHORIZATION FORM

I (we) authorize the Company to initiate entries to debit my (our) account described below

CHECKING ACCOUNT# \_\_\_\_\_ OR SAVINGS ACCT. # \_\_\_\_\_

FINANCIAL INSTITUTION NAME: \_\_\_\_\_ ROUTING # \_\_\_\_\_

This authority is to remain in full force and effect until the Company has received written notification from me of its termination in such time and manner as to afford the Company a reasonable opportunity to act on it.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
SIGNATURE (optional for Joint Acct.)

\_\_\_\_\_  
PRINT FULL NAME

\_\_\_\_\_  
PRINT FULL NAME

DATE: \_\_\_\_\_

DATE: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_

E-MAIL: \_\_\_\_\_

E-MAIL: \_\_\_\_\_