Underwritten By DENTCARE DELIVERY SYSTEMS, INC.

EXECUTIVE DENTAL & VISION PLUS

Co-Administered By Healthplex®

The Dental and Vision Plan Everyone Is Seeing Clearly to Smile About

EMPLOYEE ENROLLMENT APPLICATION

Company Name_____Policy #_____

Effective Date_____*Note: Effective Date of Coverage Must be First Day of the Month*

OPTION CHOSEN (Select One)

☐ SELECT PLAN (Dentist Selection Required From the Managed Care – Select Panel Affiliated Provider List)
No Deductible
No Annual Maximum
No Waiting Period for Major Services
No Claim Forms

☐ MANAGED CARE (Dentist Selection Required From the Managed Care – Comprehensive Panel Affiliated Provider List.)
No Deductible
No Annual Maximum
No Waiting Period for Major Services
No Claim Forms

Dentist Name_____
Dentist I.D. # _____

☐ PPO (*No* Dentist Selection Required.)

EMPLOYEE INFORMATION

Last Name _____First Name_____Middle Initial_____

Address_____Apt # _____City_____State_____Zip_____

Home Phone # (_____)_____Work Phone # (_____)_____

Social Security # _____/_____/_____ D.O.B. _____/_____/_____ Sex M ___F___ Date Employed_____

COVERAGE REQUESTED

☐ Single ☐ *Two Party ☐ *Family * If Selecting Two Party or Family Coverage Complete Dependent Information Below.

I Refuse Coverage For My Eligible Dependents. ☐ YES ☐ NO

DEPENDENT INFORMATION

Name of Spouse and Unmarried Dependents	CHECK RELATIONSHIP			BIRTHDATE		
	Spouse	Son	Daughter	Month	Day	Year

Employee Signature **X** _____ Date: _____/_____/_____

Employer Signature **X**_____ Date: _____/_____/_____

IMPORTANT **Please Type Or Write Application Neatly. Any Missing Information Will Delay Processing Your Application**
Rev 12/08