Dental Source Dental Health Care Plans

Group Enrollment Form

Part 1

1. EMPLOYER NAME — EFFECTIVE DATE

2. SOCIAL SECURITY NUMBER (required) | 3. NAME (LAST) (FIRST)

4. ADDRESS

(CITY) (STATE) (ZIP CODE)

5. WORK PHONE | 6 HOME PHONE | 7. DATE OF BIRTH (month/day/year) | 8. SEX ○ Female ○ Male

9. DEPENDANT INFORMATION - LIST ALL ELIGIBLE DEPENDANTS YOU WISH COVERED.

Part 2

NAME LAST FIRST MI	DATE OF BIRTH	SEX	RELATION TO APPLICANT

Part 3

SELECTED DENTAL LOCATION NAME | OFFICE LOCATION #

Part 4

Select a plan and coverage type.		Membership Fee	
○ Employee		$ 13.00	
○ Employee + 1		$ 20.00	
○ Family		$ 29.00	

Part 5

I have read and understand the terms and conditions of the program and hereby request membership with Dental Source of Missouri & Kansas, Inc. I further authorize my employer to deduct from my salary the $_____monthly membership fees for the Dental Source coverage that I have selected.

SIGNATURE | DATE

Part 6

Waiver of Coverage: I have been offered the plan and elect not to participate at this time. I understand that I will not be eligible to enroll in this benefit until the company's next open enrollment period or twelve months from this date.

SIGNATURE | DATE

Date Received:		Date Approved		Approved By
Agent **20184**	Broker **Robyn Hamlin**	SGA	Dist	Group

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