

**GROUP DENTAL ENROLLMENT FORM**

New Employee  
  New Group Enrollee  
  Add/Delete Dep.  
  Decline Coverage  
  Cancel Coverage  
 Open Enrollment  
  Rehire  
  Address/Name Change  
  Loss of Other Coverage  
  Transfer from PPO  
  COBRA

<b>Name of Employer:</b> Southwest Carpenters Health and Welfare Trust	<b>Group Number:</b> AAA NME 552009	<b>Div:</b>	<b>Class:</b>
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**Plan Types:**

**PREFERRED ELITE PLUS EPO DENTAL PLAN**

<b>Social Security Number:</b>	<b>Effective Date</b> Mo / Day / Year		
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<b>Last Name:</b>	<b>First Name:</b>	<b>MI:</b>	<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>  Street: _____ Apartment # _____ City, State, Zip: _____ Home Phone: _____ Work Phone: _____ Do you have other Dental Coverage? If yes, Carrier: _____	<b>Coverage Requested:</b>  <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + One Dependent <input type="checkbox"/> Employee + Two or More Dependent(s)
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<b>Complete for Dependent Coverage:</b>	<b>Do any of your dependents have other dental coverage?</b> If yes, list Carrier below
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<b>Spouse Name-Last:</b> _____ <b>First:</b> _____ <b>MI:</b> _____  <b>Sex:</b> _____	<b>Date of Birth:</b> / /	<b>Social Security Number</b>	<b>Name of Other Dental Carrier:</b>
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<b>C H I L D R E N</b>	1.		/ /		
	2.		/ /		
	3.		/ /		
	4.		/ /		
	5.		/ /		
	6.		/ /		

**I elect the dental coverage** selected for which I am eligible. I hereby apply for enrollment and authorize the release of any information relating to dental care received under the Plan and agree to all terms and conditions set forth in the Group Agreement.

**Date:** \_\_\_\_\_ **Employee Signature:** \_\_\_\_\_

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