



GROUP DENTAL ENROLLMENT FORM

<input type="checkbox"/> New Employee	<input type="checkbox"/> Decline Coverage	<input type="checkbox"/> Add/Delete Dep.	<input type="checkbox"/> Transfer from DHMO	<input type="checkbox"/> Cancel Coverage
<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Rehire	<input type="checkbox"/> Address/Name Change	<input type="checkbox"/> Loss of Other Coverage	<input type="checkbox"/> Transfer from PPO
<input type="checkbox"/> COBRA				

Name of Employer: Southwest Carpenters Health & Welfare – New Mexico	Group Number: AAA NME 552009	Div:	Class:
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Plan Types:	<input checked="" type="checkbox"/> PREFERRED ELITE EPO DENTAL PLAN
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Social Security Number:	Effective Date Mo / Day / Year		
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Last Name:	First Name:	MI:	Date of Birth Month / Day / Year	Sex: Male <input type="checkbox"/>
				Female <input type="checkbox"/>

Home Address: Street: _____ Apartment # _____ City, State, Zip: _____ Home Phone: _____ Work Phone: _____	Coverage Requested: <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + One Dependent <input type="checkbox"/> Employee + Two or More Dependent(s)
Do you have other Dental Coverage? If yes, Carrier:	

Complete for Dependent Coverage:	Do any of your dependents have other dental coverage? If yes, list Carrier below
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Spouse Name-Last:	First:	MI:	Date of Birth:	Social Security Number	Name of Other Dental Carrier:
			/ /		
		Sex:	/ /		
C	1.		/ /		
H	2.		/ /		
I	3.		/ /		
L	4.		/ /		
D	5.		/ /		
R	6.		/ /		
E					
N					

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.

Date:	Employee Signature:
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