



LIBERTY Dental Plan
 888-703-6999
 www.libertydentalplan.com
APPLICATION FOR MEMBERSHIP

Employer's Use Only

Group # 100242 Effective Date: _____

COBRA Enrollment COBRA End Date: _____

Last Name		First Name		MI	Social Security Number		Birth Date	
Street Address			City		State	Zip Code	Telephone ()	

LIST ALL DEPENDENTS TO BE COVERED UNDER YOUR PLAN

Last Name	First Name	Sex	Birth Date	Social Security Number
Spouse/ Domestic Partner				
Child				
Child				
Child				
Child				
Child				
Child				

Name of Employer/Trust

Provider ID Number

Language Preference

New Enrollment

Add Dependent

White: LIBERTY Dental Plan Copy Yellow: HR Copy Pink: Employee Copy

 Employee Signature

 Date