



Southwest  
Carpenters

CHECK ONE

**ENROLLMENT / CHANGE FORM**

- NEW ENROLLMENT  
  ADDRESS CHANGE  
  DELETE DEPENDENTS  
 CHANGE PROVIDER  
  NAME CHANGE  
  ADD DEPENDENTS

ADMIN	EMPLOYER'S USE ONLY	
PLAN	GROUP# 711785	EFF. DATE

LAST NAME		FIRST NAME		INITIAL	DATE OF BIRTH	SEX (M/F)	EMPLOYER					
HOME ADDRESS (Street and Apartment No.)							SOCIAL SECURITY NUMBER					
CITY, STATE, ZIP CODE							HOME TELEPHONE					
NAME OF SELECTED DENTIST			DENTIST #		CURRENT PATIENT <input type="checkbox"/> YES <input type="checkbox"/> NO		HIRE DATE		DATE OF MARRIAGE		MARRITAL STATUS	
RELATION TO EMPLOYEE	LAST NAME	FIRST NAME (MI)	DATE OF BIRTH M/D/Y	SEX (M/F)	DDS#	RELATION TO EMPLOYEE	LAST NAME	FIRST NAME (MI)	DATE OF BIRTH M/D/Y	SEX (M/F)	DDS#	
SPOUSE						CHILD						
CHILD						CHILD						
CHILD						CHILD						

Does Spouse have a dental plan?  Yes    No   With whom? \_\_\_\_\_ If answer is "Yes," are dependents enrolled under spouse's plan?  Yes    No

Please check if you would like to receive a copy of the "Consent for Use and Disclosure of Health Information" form.

I UNDERSTAND THAT ONCE I HAVE CHOSEN THIS PLAN, I CANNOT CHANGE UNTIL THE NEXT OPEN ENROLLMENT PERIOD. I AGREE, THAT IF I OR MY DEPENDENTS SEEK SERVICES WHEN NOT ELIGIBLE FOR COVERAGE, THAT I WILL PAY THE DENTISTS USUAL FEE.

\_\_\_\_\_  
Employee's/Subscriber's Signature

\_\_\_\_\_  
Date Signed