

**TOTAL DENTAL ADMINISTRATORS
HEALTH PLAN, INC. (TDAHP)**

Group Dental Application for Membership/Change Form

New

Change

EMPLOYEE LAST NAME (please print)		FIRST NAME	M.I.	SOCIAL SECURITY	<p>STATUS CHANGES</p> <p><input type="checkbox"/> Name change: _____</p> <p><input type="checkbox"/> Marriage (date): _____</p> <p><input type="checkbox"/> Divorce (date): _____</p> <p><input type="checkbox"/> Death (date): _____</p> <p><input type="checkbox"/> Address Change</p> <p><input type="checkbox"/> Plan Provider Change: _____</p> <p><input type="checkbox"/> Termination of Employment Date _____</p> <p><input type="checkbox"/> Cancellation of Coverage</p> <p><input type="checkbox"/> Coverage Declined</p> <p><input type="checkbox"/> Other: _____</p>
STREET ADDRESS			BIRTH DATE Month Day Year		
CITY	STATE	ZIP		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
HOME TELEPHONE	WORK TELEPHONE	Full Time Employee Date Month Day Year			
EMPLOYER NAME Carpenters Union - AZ	MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED				
NO. OF DEPENDENTS	I AM APPLYING FOR <input type="checkbox"/> SINGLE <input type="checkbox"/> TWO-PARTY <input type="checkbox"/> FAMILY				
COMPLETE FOR DEPENDENT COVERAGE					
	NAME	SEX	BIRTHDATE		
SPOUSE	_____	_____	_____		
CHILD	_____	_____	_____		
CHILD	_____	_____	_____		
CHILD	_____	_____	_____		
CHILD	_____	_____	_____		
CHILD	_____	_____	_____		
CHILD	_____	_____	_____		
INDICATE MEMBER DENTAL OFFICE SELECTED # _____		<p><i>I hereby apply for enrollment and agree to remain in the plan a minimum of one year, authorize the release of any information relating to dental care received under the plan, and to all terms and conditions set forth in the Group Agreement.</i></p>			
SIGNATURE REQUIRED x				DATE	

GROUP NUMBER 537000	PLAN A200S
MEMBER NUMBER	
EFFECTIVE DATE	

TOTAL DENTAL ADMINISTRATORS HEALTH PLAN, INC.

FOR ANY QUESTIONS CALL:
(602) 266-1995 OR 1-888-422-1995