

For use when current a medical group adds dental to their benefits package. Use this form if your and your family's dental enrollment is to match your current medical enrollment. If does not match, you must complete the long form.

Group Policy No.	Subgroup No.	Class No / Classification
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Employer Information

Employer/Group Name	Dental Effective Date
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Employee Information

Employee Last Name	First Name	M.I.	Date of Birth
			month _____ day _____ year _____

Family Information

***Social Security Numbers** are required for each family member listed. A Mandatory Insurer Reporting Law (Section 111 of Public Law 110-173) requires group health plan insurers to report information the Secretary of the Department of Health and Human Services for purposes of coordination of benefits. To coordinate Medicare payments with other insurance benefits properly, Medicare relies on the collection of both the Social Security Number (or Medicare Health Insurance Claim Numbers) and the Employer Identification Number.

****Race/Ethnicity** (choose the code each family member would most closely identify with): **A**-American Indian/Alaska Native, **B**-Asian, **C**-Black/African American, **D**-Hispanic/Latino, **E**-Native Hawaiian/Other Pacific Islander, **F**-White/Caucasian

Name	Birth Date	*Social Security Number	**Race/Ethnicity
Employee			
Spouse or Domestic Partner			
Dependent Child			
Dependent Child			
Dependent Child			
Dependent Child			
Dependent Child			

If you or your spouse are a court-ordered guardian of any dependent listed above, identify and provide proof:
 Name(s): _____ Type: Grandchild Niece/Nephew Sibling Other _____

Other Coverage

Current or Prior Coverage – Do you or anyone on this application have or have had insurance in the last 24 months? No Yes

Name(s)	Insurance Carrier	Date of coverage	Will Coverage Continue?	Type of Coverage
	Carrier Name: Policy No.: Phone No.:	Begin: End:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Retiree
	Carrier Name: Policy No.: Phone No.:	Begin: End:	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Retiree

Medicare – If you or any person on this application have Medicare, is coverage? Part A Part B Part D

Name	Original Effective Date	Medicare No. (include alpha prefix)	Reason for Medicare Entitlement
			<input type="checkbox"/> Age <input type="checkbox"/> ESRD <input type="checkbox"/> Disability <input type="checkbox"/> Dual Entitlement

Declaration

I affirm that the answers given in this application are complete and correct.

Employee Signature

Date