



EMPLOYEE ENROLLMENT AND CHANGE FORM

EMPLOYEE PLEASE GIVE YOUR COMPLETED FORM TO YOUR BENEFITS ADMINISTRATOR

4061 POWDER MILL ROAD, SUITE 325
 CALVERTON MD 20705-3149
 CUSTOMER SERVICE: 800-334-6277 FAX: 1-800-626-2579
 WWW.DENTAQUEST.COM

PLEASE PRINT OR TYPE -
 BE SURE FORM IS COMPLETED
 IN FULL TO ENSURE ENROLLMENT

ADMINISTRATOR PLEASE MAIL COMPLETED ENROLLMENT FORMS TO:
DentaQuest
 PO BOX 9708
 BOSTON, MA 02114-9708

1. EMPLOYER NAME:		2. EFFECTIVE DATE:		3. DATE OF HIRE:		4. GROUP NUMBER:	
5. LAST NAME (Subscriber):			6. FIRST NAME:		7. SOCIAL SECURITY NO.		8. DOB:
9. HOME ADDRESS				10. CITY:		11. STATE:	12. ZIP:

PLAN SELECTION

13. PLAN: Select plan you are enrolling in:
 Access **Choice** **ACCESS ePPO** **Classic** **Advantage** **The Select Plan**

14. If you have selected the Classic or Advantage plan then please Choose a General Dentist from our directory of Participating General Dentists & Specialists. Your entire family will be enrolled with the same General Dentist. If you do not choose a Participating General Dentist, one will be selected for you.

DENTIST NAME		DENTIST STREET ADDRESS		
DENTIST ID #	CITY	STATE	ZIP	

PLEASE LIST ALL ELIGIBLE DEPENDENT(S) COVERED UNDER YOUR POLICY

15. FIRST NAME	16. LAST NAME (IF DIFFERENT FROM SUBSCRIBER)	17. DATE OF BIRTH	18. CHECK IF DEPENDENT IS OVER 19 AND A FULL TIME STUDENT
SPOUSE			
CHILDREN			

19. REASON FOR SUBMISSION (CHECK ONE)

New Coverage
 Individual Individual + 1/Spouse Individual + Child Family Transfer from sublocation _____ to _____
 Termination Status change: From _____ to _____
 Add dependent to family **COBRA**
 Reinstatement Reinstatement of Subscriber
 Remove dependent _____ name Individual Individual + 1/Spouse Individual + Child Family
 Name change ___ Transfer to Cobra Sublocation _____
 Address change ___ New addition of dependent formerly covered
 Remove dep. from student status _____ name under ID # _____

20. COORDINATION OF BENEFITS
 Upon the effective date of this coverage will you or any of your eligible dependents listed above be covered by another dental plan? No Yes
 If YES, please indicate name of covered individual _____.

OTHER DENTAL INSURANCE COMPANY:	EMPLOYER NAME:	POLICY HOLDER ID NO.:	EFFECTIVE DATE
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21. Are you or any of your eligible dependents (listed above) covered by a medical plan? No Yes
 If YES, please indicate name of covered individual _____.

NAME OF MEDICAL INSURANCE COMPANY:	EMPLOYER NAME:	POLICY HOLDER ID NO.:	EFFECTIVE DATE
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I certify that all information is true and correct to the best of my knowledge. Also, I understand that the effective date and termination date of my membership will be determined by my employer or plan sponsor in accordance with the underwriting guidelines of DentaQuest. In addition, if my employer requires employee contributions for this coverage, I authorize the deduction of this amount from my wages.

26. Subscriber Signature _____	Date _____	Benefit Administrator Authorization _____	Date _____
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DentaQuest provides dental benefit programs to employers, unions, and associations located in Maryland and Washington, D.C. through DentaQuest Mid-Atlantic, Inc.; and to those located in Virginia through DentaQuest Virginia, Inc.

This is not an application for insurance

TOP: SUBMIT TO DENTAQUEST MIDDLE: GROUP COPY - RETAIN FOR YOUR FILES BOTTOM: SUBSCRIBER COPY - FOR USE AS TEMPORARY ID CARD