



## DENTAQUEST VISION PREMIER PLAN

benefits provided through Avesis

LAST NAME	FIRST	M.I.	SOCIAL SECURITY NUMBER
HOME STREET ADDRESS	CITY	STATE	ZIP CODE
HOME PHONE #	WORK PHONE #		
DATE OF HIRE (MM/DD/YY)	DATE OF BIRTH (MM/DD/YY)	SEX (CIRCLE ONE)  MALE OR FEMALE	
COVERAGE SELECTION (CIRCLE ONE)  EMPLOYEE      EMPLOYEE + ONE      FAMILY		EMPLOYER NAME	
EFFECTIVE DATE	<u>DENTAQUEST MGMT USE ONLY</u>		

DEPENDENT'S LAST NAME	FIRST	M.I.	SOCIAL SECURITY NO.	DATE OF BIRTH (MM/DD/YY)
SPOUSE				
CHILD				
CHILD				
CHILD				
CHILD				

- By my signature, I hereby request membership in the DentaQuest Vision plan.
- By my signature, I hereby decline membership in the DentaQuest Vision plan.

APPLICANT'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_