



# 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 \_\_\_\_\_

This is not an application for insurance