

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: 800-626-2579

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

ADMINISTRATOR PLEASE MAIL
 COMPLETED ENROLLMENT FORM TO:
DentaQuest[®]
 P.O. BOX 9708
 BOSTON, MA 02114-9708

www.dentaquestdental.com

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 DHMO Advantage DHMO The Select Plan Prime

14. If you have selected a DHMO 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 to 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 _____
 Status change: From _____ to _____
 Termination
 Add dependent to family
 Reinstatement
 Remove dependent _____ name
 Name change
 Address change
 Remove dep. from student status _____ name

COBRA
 Reinstatement of Subscriber
 Individual Individual + 1/Spouse Individual + Child Family
 ___ Transfer to Cobra Sublocation _____
 ___ New addition of dependent formerly covered under ID # _____

20. COORDINATION OF BENEFITS
 Upon the effective date of this coverage will you and 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 Mid-Atlantic, Inc. 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