CBA Benefit Services

NOTE: please print except for signature

Employer:_____

DENTAL ENROLLMENT/CHANGE FORM

Employee Information

Employee Name: **Last** **First** **Middle Initial**			**Social Security #** --- ---	**Sex** ❒ M ❒ F	**Date of Birth (mm/dd/yy)** --- ---
Street Address:		Home Phone #: ( )	**Marital Status:** ❒ Single ❒ Married ❒ Divorced ❒ Widowed ❒ Legally Separated		**Apply For:** ❒ Self ❒ Self & Family ❒ Waive Coverage
City:					
State: Zip:					
Occupation:	Date Employed: --- ---	Business Phone #: ( )			

Use this space to list all eligible dependents. Last name required if different from employee's.

NAME	DATE OF BIRTH (mm/dd/yy)	SEX	SOCIAL SECURITY #	RELATIONSHIP	FULL TIME STUDENT
Spouse:	--- ---	❒ M ❒ F	--- ---	Spouse	N/A
Dependent:	--- ---	❒ M ❒ F	--- ---	❒ Son ❒ Daughter ❒ Other _____	❒ Yes ❒ No
Dependent:	--- ---	❒ M ❒ F	--- ---	❒ Son ❒ Daughter ❒ Other _____	❒ Yes ❒ No
Dependent:	--- ---	❒ M ❒ F	--- ---	❒ Son ❒ Daughter ❒ Other _____	❒ Yes ❒ No
Dependent:	--- ---	❒ M ❒ F	--- ---	❒ Son ❒ Daughter ❒ Other _____	❒ Yes ❒ No

Are you or any of your covered dependents covered by other Group Insurance?
Check: ❒ No ❒ Yes – fill out following information:

Other Insurance Information:	
Name of Person covered by other insurance:	Social Security # --- ---
Name of Company this Person works for:	Group #
Name of Other Insurance Company:	
Address of Other Insurance Company:	

FRAUD NOTICE: Any person who knowingly, and with intent to injure, defraud or deceive any insurance company files a statement of claim containing false, incomplete or misleading information is guilty of criminal and/or civil offense.

RELEASE OF INFORMATION: I authorize the release of any medical, dental or other information concerning me or my family members needed to process a health benefit claim. This consent is valid until revoked in writing by me.

EMPLOYEE SIGNATURE: _____ **DATE:** _____

EMPLOYER USE ONLY:
Employer Rep: _____ Effective date: _____
❒ New Enrollment ❒ Re-Enrollment ❒ Open Enrollment
❒ Reinstatement ❒ Name Change/Formerly: _____
❒ Address change
❒ Add Dependent (complete above in "list all eligible dependents" section)
❒ Drop Dependent
Name: _____
Reason: _____
Effective date for change: _____
DISTRIBUTION: Original to CBA Benefit Services. Retain copies as needed.

CBA ONLY: Processed Date: _____/_____/_____ User ID: _____