

# 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 <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm/dd/yy) --- ---	
Street Address:			Home Phone #: ( )	<b>Marital Status:</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated		<b>Apply For:</b> <input type="checkbox"/> Self <input type="checkbox"/> Self & Family <input type="checkbox"/> 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:	--- ---	<input type="checkbox"/> M <input type="checkbox"/> F	--- ---	Spouse	N/A
Dependent:	--- ---	<input type="checkbox"/> M <input type="checkbox"/> F	--- ---	<input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent:	--- ---	<input type="checkbox"/> M <input type="checkbox"/> F	--- ---	<input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent:	--- ---	<input type="checkbox"/> M <input type="checkbox"/> F	--- ---	<input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent:	--- ---	<input type="checkbox"/> M <input type="checkbox"/> F	--- ---	<input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other _____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Are you or any of your covered dependents covered by other Group Insurance?

Check:  No     Yes – fill out following information:

<b>Other Insurance Information:</b>	
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.

**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: \_\_\_\_\_

EMPLOYEE SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_