DENTAL PAY PLUS

VOLUNTARY

100 Corporate Parkway, Suite 342
Amherst, New York 14226
(716) 831-8171

ENROLLMENT AND CHANGE FORM

Plan Holder Name (Company Name)	Division	**Effective Date**:
Plan Holder Street Address	Hire Date	☐ Male ☐Female
Employee's Name (Last, First, MI) ☐ Mr. ☐ Miss ☐ Mrs. ☐Ms	Birthdate	SS#
	☐ New Applicant ☐ Change ☐ COBRA Eff. Date:_____	
Employee's Address (Incl. Apt. No.),City, State, Zip	Home Phone	
	Coverage Requested ☐ Single ☐ Family	

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Legally Separated ☐ Divorced

Give the following information for each dependent to be insured: Name (Last, First, MI)	**Relationship**	**Sex**	**Birth date**	**Full-Time Student**
1.		☐ Male ☐ Female		☐ Yes ☐ No
2		☐ Male ☐ Female		☐ Yes ☐ No
3.		☐ Male ☐ Female		☐ Yes ☐ No
4.		☐ Male ☐ Female		☐ Yes ☐ No
5.		☐ Male ☐ Female		☐ Yes ☐ No
6.		☐ Male ☐ Female		☐ Yes ☐ No

Are any dependent children adopted?	☐ Yes	☐ No	If "Yes", indicate name and date of adoption:
Have you included step-children as dependents?	☐ Yes	☐ No	If "Yes", indicate name is:
Do your step-children reside with you?	☐ Yes	☐ No	Are they dependent upon you for support and maintenance? ☐ Yes ☐ No

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud. I have reviewed the statements on this application and they are true and complete.

X_____ _____

(Signature of employee) (Date)