DENTAL MEMBERSHIP ENROLLMENT / CHANGE FORM

TO BE COMPLETED BY EMPLOYEE

Social Security Number	Last Name	First Name	Middle Initial

Street Address	City	State	Zip
Mailing Address	City	State	Zip

Date of Birth	Phone #	Sex ☐ Male ☐ Female	Coverage Start Date	Effective Date of Change (If Applicable)

Employer Name	Division	Date of Hire	Job Title

Do you currently have other dental care coverage? ☐ Yes ☐ No If Yes, with what company?
Carrier Contract or Policy #:

You must provide proof of prior coverage within 30 days of your eligibility date to have waiting periods waived.

WAIVING OR DECLINING OF COVERAGE

☐ I am declining election of Dental Care Coverage for me and my eligible dependents.

ADDING, DELETING or CHANGING A DEPENDENT:
You must provide documentation of qualifying event when adding or removing a dependent

ADD	DELETE	CHANGE	LAST FIRST MI	SSN #	Gender	Date of Birth	Other Dental Coverage: Contract or Policy Holder Id No.	Other Dental Coverage: Current Dental Care Coverage Co.	Child Custody Information[3] YES / NO	Full-Time Student[2] YES / NO
			Spouse							
			Dependent							
			Dependent							
			Dependent							
			Dependent							

Reason for Adding or Removing a Dependent (please check): ☐ Marriage ☐ Divorce ☐ Death ☐ Military Service ☐ Child Employed ☐ Maximum Age ☐ Loss of Other Coverage
Date of Qualifying Event: ☐ Court Ordered ☐ Eligibility Status Change ☐ Open Enrollment ☐ New Born

[2] If over age 18 is the dependent a full–time student? If yes – attach a copy of documentation. [3] If court order or divorce decrees are you the party responsible for coverage?

I affirm that the answers in this application are complete and correct. I understand and agree that no coverage shall be in force until approved by the Advantage Dental Plan, Inc. If approved, coverage will be in force as of the effective date determined by Advantage Dental Plan, Inc.

Signature Date: / /

Advantage Dental Plan® Phone: (866) 268-9670 Fax: (541) 504-3908 442 SW Umatilla Ave. Suite 200 Redmond, OR 97756

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