



THE DENTAL NETWORK

"Plans to Make You Smile - Now and Into the Future"

7400 York Road Towson, Maryland 21204-7502

Tel (410) 847-9060 Fax (410) 847-9062

Toll Free 1-888-833-8464

Website: www.thedentalnet.org

Email: service@thedentalnet.org

UNDERWRITTEN BY:

Colorado Bankers Life Insurance Company

ADMINISTERED BY:

The Dental Network, Inc.

DENTAL ENROLLMENT FORM

Employee, please print or type. Complete all areas, sign and date.
Do not write in shaded areas.

Name (last, first, middle initial)		FOR OFFICE USE ONLY		Group No. _____
Home Address (street)		Date of Birth	Eligibility Date _____	
City	State	Zip	Home Telephone ()	Business Telephone ()
Your Employer	Employer Address (street, city, state, zip code)			
Social Security Number (Required)				
- -				

Spouse Information - Complete only if spouse is to be covered.

Name of Spouse (first, middle initial)(Last - only if different)	Is your spouse covered under any other dental Plan?	Date of Birth	Sex
	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Male <input type="checkbox"/> Female

Dependent Children - List only those children to be covered.

Name (first, middle initial)(last only if different)	Date of Birth	Relationship	Sex	Check if over age 19	Name of accredited school
			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Full time student <input type="checkbox"/> Handicapped child	
			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Full time student <input type="checkbox"/> Handicapped child	
			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Full time student <input type="checkbox"/> Handicapped child	
			<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Full time student <input type="checkbox"/> Handicapped child	

<input type="checkbox"/> Initial Enrollment	<input type="checkbox"/> Policy Change
____EMPLOYEE	Reason for change in coverage:
____EMP/CHILD(REN)	1. ____Married
____EMP/SPOUSE	2. ____Widowed
____FAMILY	3. ____Divorced
	4. ____Birth/Adoption
	5. ____Address Change
	6. ____Other

I authorize my employer to deduct from my pay any premium required of me toward the cost of elected dental coverage.

I agree on behalf of myself and any dependent(s) named above to provide Colorado Bankers Life Insurance Company or its appointed representative with information to process this enrollment form or to administer eligible benefits.

Employee's signature _____

Date _____