



THE DENTAL NETWORK

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

Employee Enrollment Form

Suite 200, 7400 York Road ▼ Towson, MD 21204
Telephone (410) 847-9060 ▼ Toll-Free (888) 833-8464
Fax (410) 847-9062 ▼ Website: www.thedentalnet.org

1. Subscriber Information

Last Name		First Name		MI	Social Security Number - -	
Street Address				Apartment No.	Employment Date / /	
City		State		Zip Code		Employment Status <input type="checkbox"/> Active <input type="checkbox"/> Retired
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth / /		Home Phone Number () -		Business Phone Number Ext. () -	
Name of Employer				Department		

2. Coverage Selection

<input type="checkbox"/> Individual	<input type="checkbox"/> Parent / Child	<input type="checkbox"/> Husband / Wife	<input type="checkbox"/> Family
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3. Dependent Information (DENTAL OFFICE MUST BE SELECTED IN ORDER FOR POLICY TO BECOME EFFECTIVE)

Subscriber Dental Office Selected: _____ Code No.: _____

List All Of Your Dependents Below:

	LAST NAME	FIRST NAME	MI	SEX (M/F)	BIRTH DATE	SOCIAL SECURITY NUMBER	DENTAL OFFICE CODE
Spouse							
Child							
Child							
Child							
Child							

4. Additional Dependent Information

Are any of your dependents covered by Medicare?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dependent Name _____
Are any of your dependents disabled?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Effective date of disability: _____
Name _____		
Full Time (19 or over) students?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
1. Name _____	School Name _____	Exp. Grad. Date _____
2. Name _____	School Name _____	Exp. Grad. Date _____

I hereby agree to remain in the PLAN a minimum of one (1) year. Less than a one-year membership may result in my being billed Normal and Customary Fees, less Cost for Services and Covered Employee Copayments paid, as those terms are defined in the Certificate of Coverage.

SIGNATURE: _____ DATE: _____

FOR OFFICE USE ONLY		
Effective date: _____	Department: _____	Plan No.: _____
Group No.: _____	Approved by: _____	Rate: _____