

TYPE PROGRAM

ConcordiaPLUS
 Concordia Select
 Concordia Preferred
 Concordia Flex

- New Enrollment
- Change (specify)
 - Add Dependent/Spouse
 - Change Dentist
 - New Address
 - Change of Employee Status
 - Cancel Dependent/Spouse
 - Cancel Contract
 - Reinstate
 - Other (specify): _____

EFFECTIVE DATE			

GROUP NUMBER SUB GRP			

PAYROLL LOC.			

NOTE: Incomplete information on this form will delay your enrollment.

Social Security Number		Employee Name (Last, First, Middle Initial)		Date of Birth	
Home Address				Home Phone ()	
City		State	Zip Code	Work Phone ()	
Date of Marriage / /		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated			
Previous Dental Insurance					
Employer Name			Employer Address		
Date Hired / /		Employee Number		Employee Type: <input type="checkbox"/> Current <input type="checkbox"/> New <input type="checkbox"/> Rehire <input type="checkbox"/> Open Enrollment <input type="checkbox"/> COBRA	
Employee Status: <input type="checkbox"/> Hourly <input type="checkbox"/> Salaried (Union Represented) <input type="checkbox"/> Management <input type="checkbox"/> Salaried (Not Union Represented) <input type="checkbox"/> COBRA <input type="checkbox"/> Retiree					

PLEASE LIST HERE ALL FAMILY MEMBERS TO BE COVERED BY THIS ENROLLMENT.

Last Name	First Name	MI	Sex	Date of Birth	Social Security Number	For ConcordiaPLUS, provide your Primary Care Dentist No. from listing provided (if current dentist <input checked="" type="checkbox"/> block)
Self				/ /	- -	
Spouse				/ /	- -	
Child				/ /	- -	
Child				/ /	- -	
Child				/ /	- -	

IF ANY OF THE CHILDREN LISTED ABOVE ARE HANDICAPPED (H), FULL-TIME STUDENTS (S) AGE 19 AND OVER, OR GRANDCHILDREN (G), PLEASE MARK AN "H", "S", OR "G" BESIDE THE CHILD'S NAME.

Important: Do you or your dependent(s) have other Group Dental Coverage? Yes No
 If your answer to the above question is yes, please complete the following information.

Name of Insured	Insurance Company	Policy Number
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IMPORTANT: PLEASE READ AND SIGN BELOW. I REPRESENT THAT ALL INFORMATION SUPPLIED IN THIS APPLICATION IS TRUE AND COMPLETE.

Employee's Signature: _____ Date: _____

Employer's Signature: _____ Phone No: _____ Date: _____

