



# Dental Membership Enrollment Form

Anthem  
Dental Enrollment Department  
PO Box 1193  
Minneapolis MN 55440-1193

## PART A – EMPLOYEE INFORMATION – Employee complete Parts A thru E and return form to benefit administrator.

<b>Employee's Name:</b>		Last		First		Middle Initial		<b>Social Security Number</b>					
Gender:		Male	Female	<b>Marital Status:</b>		Single	Married	Widowed	Divorced	Legally Separated	<b>Date of Birth (Month-Day-Year)</b>		
<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		/ /	
<b>Employee's Address:</b>		Address				Home Phone Number			Work Phone Number				
		City				State			Zip Code				

## PART B – ENROLLMENT INFORMATION

<b>Select Coverage Type (Check One Box Only):</b>		<b>Complete if Multiple Plan Options Are Offered</b>	
<input type="checkbox"/> Employee Only*	<input type="checkbox"/> No Coverage*	I elect to participate in the following Plan:	
<input type="checkbox"/> Employee and Spouse	* If waiving coverage for employee and/or any eligible family members, you must complete Part D.	<input type="checkbox"/> Plan A <input type="checkbox"/> Plan B <input type="checkbox"/> Plan C <input type="checkbox"/> Plan D	
<input type="checkbox"/> Employee and Dependent Child(ren)			
<input type="checkbox"/> Family			

## PART C – DEPENDENT INFORMATION

Relationship To Employee	First Name, Middle Initial, Last Name (Include Last Name Only if Different From Employee's)	Gender		Date of Birth Month/Day/Year	Full Time Student?		Unmarried?	
Spouse		M	F	/ /				
Dependent Child		M	F	/ /	Y	N	Y	N
Dependent Child		M	F	/ /	Y	N	Y	N
Dependent Child		M	F	/ /	Y	N	Y	N

## PART D – EMPLOYEE SIGNATURE – Select One

Do you (the employee) have other dental coverage?  Yes  No Do your dependents have other dental coverage?  Yes  No  
 Name of Carrier: \_\_\_\_\_ Policy/Identification Number: \_\_\_\_\_

I waive coverage for myself and/or my dependents and understand that by waiving coverage, whether entirely or partially paid by my employer, that I waive the right to change this selection unless permitted in the group contract's participation requirements and enrollment restrictions. Anthem Blue Cross and Blue Shield reserves the right to decline any further dental enrollment changes.

**Employee Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

I am enrolling myself and/or my dependents and authorize payroll deductions, if applicable. I have read, or have had read to me, the completed application and I realize that any false statement or misrepresentation in the application may result in a loss of coverage under the policy.

**Employee Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## PART E – GROUP ENROLLMENT INFORMATION - THIS PART TO BE COMPLETED BY EMPLOYER

<input type="checkbox"/> <b>New Group</b> Hire Date: _____/_____/_____ Prior Coverage Start Date (if applicable): _____/_____/_____ Coverage Effective Date: _____/_____/_____	<input type="checkbox"/> <b>Rehire Date Lay Off Began:</b> _____/_____/_____ <b>Date Rehired:</b> _____/_____/_____
<input type="checkbox"/> <b>Existing Anthem Dental Group</b> Hire Date: _____/_____/_____ Prior Coverage Start Date (if applicable): _____/_____/_____ Coverage Effective Date: _____/_____/_____	<input type="checkbox"/> <b>Return from Leave of Absence</b> Date Leave Began: _____/_____/_____ Date Returned to Work: _____/_____/_____
<input type="checkbox"/> <b>New Hire – Apply Probationary Period (if applicable) to determine Effective Date</b> Hire Date: _____/_____/_____ Effective Date: _____/_____/_____	<input type="checkbox"/> <b>Employee Change Part Time to Full Time</b> Date of Status Change: _____/_____/_____ Effective Date: _____/_____/_____
<input type="checkbox"/> <b>Open Enrollment</b> Effective Date: _____/_____/_____	<input type="checkbox"/> <b>Previously Waived Coverage or Loss of Coverage</b> Qualifying Event Reason: _____ Hire Date: _____/_____/_____ Event Date: _____/_____/_____ Effective Date: _____/_____/_____
<b>Group Name:</b> _____	
<b>Group &amp; Subgroup Numbers:</b> _____	
<b>Group Representative's Signature:</b> _____	
<b>Date:</b> _____ <b>Phone Number:</b> ( ) _____	

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