DHMO ENROLLMENT FORM

EMPLOYEE	LAST NAME	FIRST	INITIAL	DATE OF BIRTH MO	DAY	YR	SEX M	F

STREET ADDRESS	APT#	EMAIL ADDRESS	SOCIAL SECURITY NUMBER

CITY	STATE	ZIP	HOME PHONE ( )
			WORK PHONE ( )

DATE EMPLOYED	EMPLOYER (GROUP)	GROUP #	CHOOSE DENTAL OFFICE Write dentist number from list.

LIST ALL ELIGIBLE DEPENDENTS TO BE COVERED BELOW

LAST FIRST INITIAL	DENTAL FACILITY#	DATE OF BIRTH MO	DAY	YR	SEX M	F	# OF DEPENDENTS COVERED
SPOUSE							
CHILD: 1							COVERAGE FOR
CHILD: 2							☐ Individual
CHILD: 3							☐ Member and one dependent
CHILD: 4							☐ Family
CHILD: 5							

EFFECTIVE DATE - 1ST OF THE MONTH	PREMIUM AMOUNT	AMOUNT PAID	PLAN #	AGENT #

I hereby authorize the Group to deduct monthly for 12 months, and future renewal period(s) my portion of such subscription fee from any funds due me. I understand that enrollments are by Group contract and/or for consecutive 12 month period(s) and my subscription fee is subject fee is subject to change on the anniversary date of the Group. I hereby represent to the carrier that all information furnished by me hereon is true and complete to the best of my knowledge. I hereby consent, personally and on behalf of any family member enrolled, to the unrestricted release of my/our dental records maintained by participating dentists to CompBenefits for, but not limited to, claims verification and quality assessment review, and to any other participating dentist who may be or become involved in my/our dental care.

_____

X Signature

_____

X Date

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against the Plan, submits an enrollment form or files a claim containing a false or deceptive statement is guilty of insurance fraud.

This is a CompBenefits Corporation Benefit Plan.