



# Dental Enrollment Application and Change of Information Form

You must complete this enrollment form to participate in the dental plan Willamette Dental of Idaho, Inc.

TYPE OF APPLICATION:  New Application  Change of Information

COBRA\*  18 Months  29 Months  36 Months \*Continuation Qualifying Event Date: \_\_\_\_\_

PLEASE TYPE OR PRINT - PRESS FIRMLY - ALL ITEMS MUST BE COMPLETED

LAST NAME		FIRST NAME		M.	MALE	FEMALE	SOCIAL SECURITY NUMBER		
ADDRESS						HOME PHONE			
CITY		STATE		COUNTY		ZIP CODE		WORK PHONE	EFFECTIVE DATE
SINGLE <input type="checkbox"/>	MAR. <input type="checkbox"/>	DIV. <input type="checkbox"/>	WIDOW(ER) <input type="checkbox"/>	BIRTH DATE		OCCUPATION		DATE EMPLOYED FULL TIME	PLAN NAME
NAME OF EMPLOYER			ADDRESS			CITY		STATE	ZIP CODE

I AM ENROLLING MYSELF ONLY  I AM ENROLLING MYSELF & DEPENDENTS (LIST DEPENDENTS INFORMATION BELOW)

RELATIONSHIP CODES  
 A - Natural Child B - Step Child  
 D - Legally Adopted E - Domestic Partner  
 C - Foster Child F - Other (Explain)

	SSN#	IS SPOUSE EMPLOYED? <input type="checkbox"/> NO <input type="checkbox"/> YES	DOES CHILD RESIDE WITH YOU? <input type="checkbox"/> NO <input type="checkbox"/> YES	DATE OF BIRTH			SEX	
				MONTH	DAY	YEAR	MALE	FEMALE
LEGAL SPOUSE (FULL NAME)								
NAMES OF ALL CHILDREN								

IMPORTANT: IF YOU ARE ENROLLING A DEPENDENT CHILD AGE 19 OR OLDER, COMPLETE THE STUDENT INFORMATION ON THE REVERSE SIDE.

To change enrollment information, please provide the appropriate information below.

- Change Address - Complete address section on reason line below.
- Add Dependent - Complete dependent section and note reason and effective date on reason line below.
- Delete Dependent - Complete dependent section and note reason and effective date on reason line below.
- Name Change - Note effective date and old/new names on the reason line below.
- Termination  Open Enrollment

Reason: \_\_\_\_\_

## Other Dental Plans

ARE YOU OR ANY OF YOUR DEPENDENTS COVERED BY ANOTHER DENTAL PLAN?

YES  NO IF YES, NAME OF MEMBER: \_\_\_\_\_

NAME OF CARRIER

POLICY NUMBER

## Application/Authorization/Certification

I hereby apply for coverage through Willamette Dental of Idaho, Inc. for myself and for my listed dependents. I am familiar with the terms of the coverage, including provisions dealing with emergencies, covered services through participating dentists and services which require co-payments, payable by me or my dependents directly to the provider of such services.

I authorize my employer to make payroll deductions from my salary or wages in the amount required, if any, to cover my contribution to coverage with Willamette Dental of Idaho, Inc.. I authorize any other provider of health services to give Willamette Dental of Idaho, Inc., upon request, any information concerning the health, condition, or treatment of any person included under such coverage whenever such information is considered necessary for the proper disposition of a claim in fulfillment of obligations imposed on Willamette Dental of

Idaho, Inc. by State or Federal law. I certify that all information supplied in this application is true and complete to the best of my knowledge. I agree to advise Willamette Dental of Idaho, Inc. of any change in status within 60 days from the date of change. Limited to two years within filing this form, I understand that my membership is null and void if I have provided any information which is false or misleading regarding myself or my dependents on this form or any form filed in conjunction with this health plan.

SIGNATURE

DATE