BeneCare® DENTAL PLANS

THE DENTAL CONNECTION
DentalCare
Enrollment/Change Request

administered by
BeneCare Dental Plans

Refer to instructions on back before completing this form. Print clearly.

Subscriber Group Information - To Be Completed by Sponsor

Company Name

A. Type of Activity - To Be Completed by Sponsor

1. Enrollment
☐ New Subscriber
Effective Date / /
Date of Hire / /

2. Change - *Check all that apply* **Date of Event**
☐ Add Spouse / /
☐ Add Dependent Child / /
☐ Name Change / /
☐ Change Plan / /
☐ Other / /

3. Remove or Terminate
Check all that apply **Effective Date**
☐ Remove Spouse / /
☐ Remove Dependent Child / /
☐ Subscriber Withdrawl/Termination / /
NOTE: Subscriber must be enrolled for spouse/ dependent(s) to have coverage.

4. Continuation of Coverage, i.e., COBRA
Coverage For:
☐ Subscriber ☐ Dependents
Length of Continuation:
☐ 12 mos ☐ 18 mos ☐ 29 mos ☐ 36 mos
Date of Loss of Coverage: / /
Date of Qualifying Event: / /

B. Subscriber Information - Complete Sections B - G.

Social Security Number	**Last Name, First Name, M. I.**		**Home Telephone** ( )
Home Address	**Apt. No.**	**City, State**	**ZIP Code**
Sponsor Name			**Work Telephone** ( )
Work Address		**City, State**	**ZIP Code**

C. Plan Option

Check One:
☐ CHOICE PPO
☐ CHOICE ACCESS
☐ CHOICE ACTIVE PPO
☐ CHOICE ESSENTIAL PPO

Your selection must be offered by your Sponsor.

D. Individuals Covered - List individuals for whom you are adding/changing/removing coverage. Attach sheet to list add'l. children. Attach proof if f.t. college student.

	(A)dd (C)hange (R)emove	**Last Name, First Name, M.I.**	**Sex** M / F	**Social Security Number**	**Birthdate** MM / DD / YYYY
Subscriber					/ /
Spouse					/ /
Child					/ /
Child					/ /
Child					/ /

E. Other Dental Insurance

Is your Spouse Employed? ☐ **Yes** ☐ **No**
If "Yes", give name & address of spouse's employer.

If spouse or dependents have other dental coverage, give name a policy number of insurance carrier, HMO or other source.

F. Subscriber Signature
I represent that all of the information supplied in this application is true and complete.

If you have questions concerning the benefits and services provided by or excluded under the Plan, contact a Member Services representative at 1-888-843-4727 before signing this form.

G. Sponsor Verification - To Be Completed by Sponsor

Subscriber Signature - *Required*	**Date** / /	**Sponsor Signature - *Required***	**Title**	**Date** / /