DENTAL ENROLLMENT

Employee: Last Name	First Name		Middle Initial
Social Security #	Date Of Birth	Male	Female
Address	City	State	Zip

COVERAGE FOR:

☐ EMPLOYEE ONLY ☐ EMPLOYEE AND SPOUSE ☐ FAMILY
☐ EMPLOYEE AND CHILD / CHILDREN

PLEASE COMPLETE THE FOLLOWING ONLY IF YOU ARE COVERING YOUR DEPENDENTS

Name	Soc. Sec . #	Relationship	Date of Birth	Sex
1.		**Self**		
2.		**Spouse**		
3.				
4.				
5.				
6.				

Is your spouse employed? ☐ YES ☐ NO

If yes, does your spouse have dental coverage through their employer? ☐ YES ☐ NO

If yes, give the name and address of employer and name and address of carrier / TPA providing dental coverage:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

I certify that I am an active full time employee for the employer named below**:**

Mo. Day Year **Signature Of Employee**

EMPLOYER'S STATEMENT

Effective Date (mm/dd/yy)	Hire Date (mm/dd/yy)	**Occupation:**
If effective date is different than hire date, please check one: ☐ waiting period ☐ late entrant ☐ open enrollment		
Name of Employer:		**Co I.D. No.**

Underwritten by: BOSTON MUTUAL LIFE INSURANCE COMPANY -1891-

Employer-Authorized Signature and Title

Benefit Administrators, Inc.
1250 Tower Lane • P.O. Box 6279
Erie, PA 16512