Companion Life

TDA
Total Dental Administrators, Inc.

UTAH

GROUP DENTAL ENROLLMENT FORM

☐ New Employee	☐ Add Coverage	☐ Change Dependent	☐ Address Change	☐ Cancel Coverage

Name of Employer: (Use Name from Group Billing Notice or Master Application)	Group Number:	Div:	Class:

Plan Types:

☐ **TC-4000 Program**

☐ Dental office selected #

Social Security Number	**Effective Date** Month / Day / Year	**Date Employed Fulltime** Month / Day / Year	**Hours Worked Per Week**

Your Name (Last), (First), (MI)	**Date of Birth** Month / Day / Year	**Sex:** Male: ☐ Female: ☐

Home Address:

Home Phone Number: Work Phone Number:

Do you have any other Dental coverage? If so, Carrier________________________.

Coverage Requested:

☐ **Employee Only**

☐ **Employee + 1**

☐ **Employee + 2**

☐ **Employee + 3 or more**

Complete for Dependent Coverage:

	Spouse Name: (Last), (First), (MI)	Sex:	**Date of Birth:**	**Do any of your dependents have any other dental coverage?**	**If so, Name of Carrier:**
			/ /	☐ Yes ☐ No	
CHILDREN	1.	/	/ /	☐ Yes ☐ No	
	2.	/	/ /	☐ Yes ☐ No	
	3.	/	/ /	☐ Yes ☐ No	
	4.	/	/ /	☐ Yes ☐ No	
	5.	/	/ /	☐ Yes ☐ No	
	6.	/	/ /	☐ Yes ☐ No	

Fraud Warning (Not Applicable in AZ): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a 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 elect the dental coverage selected for which I am eligible. If any contribution from me is necessary to pay part of the cost of insurance. I authorize my employer to deduct the contribution from my wages.

Date **Employee Signature:**

Refusal of Group Dental Coverage: I have been offered this insurance coverage and decline to purchase it at this time. I understand that in the event I desire such insurance at a later date, I will be required to furnish evidence of insurability at my own expense, and the company will have the right to refuse any request.

Date **Employee Signature:**

Underwritten by: COMPANION LIFE INSURANCE COMPANY
Columbia, South Carolina

Return To:
Total Dental Administrators, Inc.
2111 East Highland Avenue, Suite B-425
Phoenix, AZ 85016-4735

10/1/03