

DENTAL ENROLLMENT FORM

INSTRUCTIONS

1) Fill	Out	Completely
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- 2) Choose a Dental Office 3) Print Firmly & Legibly

- 4) Sign and Date this Form
- 5) Use Pink Copy as Your Temporary I.D.

) Read Terms and Conditions on Reverse Side

FOR EMPLOYER USE ONLY									
MO.	DAY	YEAR							

EMPLOYER		DATE FIRST WORKED		CONTRACT DESIRED	CONTRACT Please select one of the DESIRED SINGLE FAM						
	LAST NAME		FIRST NAME		MIDDLE INITIAL	SEX	DA ⁻ MO	TE OF B	IRTH YEAR	SOCIAL SECURITY NO.	
EMPI	LOYEE										
SPOL	JSE										
DEPENDENT CHILDREN											
E											
HOME ADDRESS			MOBILE PHONI	DBILE PHONE				WORK PHONE			
CITY	,	STATE	ZIP		HOME PHONE						
Please	e select one of the following options										
					Kenosha 7117 Green Bay Rd.] Sturtevant 10155 Washington Ave.		
	☐ Appleton - North 2115 E. Evergreen Dr.	☐ Green 430 Ma	Green Bay 430 Main St.		Milwaukee - Beerline B 220 E. Pleasant St.				Waukesha 1211 Dolphin Ct.		
	☐ Fond du Lac 545 E. Johnson St.		Green Bay - Howard 2340 Duck Creek Pkwy.		Milwaukee - Downtown 205 E. Wisconsin Ave.				☐ Wauwatosa 11711 W. Burleigh St.		
	☐ Franklin 6855 S. 27th St.	☐ Green N1737	enville 37 Lily of the Valley Dr.		Milwaukee - Miller Park Way 2100 Miller Park Way						
IHE	REBY APPLY FOR ENROLLMENT SUI	BJECT TO THE TERMS	AND CONDITIONS ON RE	EVERSE SI	DE.						
SIGI	SIGNATURE X DATE SIGNED										
CP-40	1EF										

TERMS AND CONDITIONS

- 1. All statements and answers in this application are representations made by the member on behalf of himself/herself and other persons named in the application, if any, to induce the insurance of the dental contract applied for.
- 2. The Applicant, on behalf of himself/herself and other persons named in the application, if any, consents, authorizes and directs any physician, dentist, consultant, hospital or other person or corporation by whom or in which any diagnosis, medical, surgical or dental treatment or advice is being, shall be or shall have been rendered to furnish and make available to Care-Plus Dental Plans, Inc., all such medical, surgical and dental reports, records and other information as they may request, at no cost to them.
- 3. The contract applied for will become effective only upon the acceptance of this application by Care-Plus Dental Plans, Inc. to be evidenced by the insurance of Identification Card(s) which will be delivered to the Group or to the Member designated herein as the Applicant.
- 4. The member authorizes the Group as his remitting agent to deduct from his wages or salary a sufficient amount to provide for the regular and timely prepayment of the prevailing subscription fees that are not otherwise contributed for the contract applied for, and to remit the same for him and on his behalf to Care-Plus Dental Plans, Inc. as specified in the agreement between Care-Plus Dental Plans, Inc. and the Group.