DENTAL ENROLLMENT FORM

PREFERRED PGP GROUP PLANS, INC.

☐ NEW EMPLOYEE ☐ CHANGE

GROUP NAME _____

EMPLOYER NAME _____ EMPLOYER LOCATION _____

EMPLOYEE NAME Last _____ First _____ Middle _____ S.S.# _____

HOME ADDRESS _____

CITY _____ STATE _____ ZIP _____

BIRTHDATE _____ SEX: ☐ Male ☐ Female

MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Separated DATE OF EVENT: _____

CHECK DESIRED COVERAGE: ☐ INDIVIDUAL ☐ FAMILY

DO YOU OR YOUR SPOUSE HAVE ANY OTHER DENTAL INSURANCE AT PRESENT? ☐ YES ☐ NO

IF YOU HAVE ANSWERED "YES" TO THE ABOVE QUESTION, COMPLETE THE FOLLOWING WHERE APPLICABLE.

Name of Enrollee in Other Plan: _____

Enrollee's Place of Employment: _____ Date: _____

Address: _____

Name of Other Insurance Company: _____ Policy # _____

Type of Coverage: ☐ Individual ☐ Family

DEPENDENT LIST

Last Name	First Name	Date of Birth	Relationship	Sex	Disabled	Student
1.					Yes ☐	Yes ☐
2.					Yes ☐	Yes ☐
3.					Yes ☐	Yes ☐
4.					Yes ☐	Yes ☐
5.					Yes ☐	Yes ☐
6.					Yes ☐	Yes ☐

ENROLLEE STATEMENT

I swear that all above information is true and complete.

SIGNATURE _____ DATE _____

EMPLOYER STATEMENT

WORK STATUS: Full-Time ☐ Part-Time ☐ On Leave ☐

Date of Employment: _____ Effective Date: _____ Termination Date: _____

Location: _____

EMPLOYER REPRESENTATIVE _____ DATE _____

(Signature)