



NORTHWEST DENTAL BENEFITS

NEW ENROLLMENT

Please complete all sections of this form.

SECTION A: GENERAL INFORMATION

TYPE OF PROGRAM

NWDB – Blue Square Plan

PLAN (check one)

- ☐ Employee Only
☐ Employee + Spouse
☐ Employee + Child
☐ Employee + Children
☐ Employee + Family

EFFECTIVE DATE: _____

EMPLOYER: _____

GROUP NUMBER: _____

SECTION B: EMPLOYEE INFORMATION (please print clearly)

Social Security Number

____/____/____
Original Employment Date (mm/dd/yyyy)

☐ M ☐ F

Employee Name

____/____/____
Date of Birth

Email Address

Home Address

City

ZIP Code

SECTION C: DEPENDENT INFORMATION

(Please list any added/cancelled dependents in this section. For more than four dependent children, complete and attach an additional form.)

Social Security #	Type	Last Name	First Name	MI	Gender	Date of Birth
	Spouse/ Domestic Partner				M / F ☐ ☐	
	Dependent (A)				M / F ☐ ☐	
	Dependent (B)				M / F ☐ ☐	
	Dependent (C)				M / F ☐ ☐	
	Dependent (D)				M / F ☐ ☐	

SECTION D: OTHER DENTAL COVERAGE

(Please list any added/cancelled dependents in this section. For more than four dependent children, complete and attach an additional form.)

Do you have another dental policy with Northwest Dental Benefits?

☐ YES ☐ NO

If yes, please provide the following information:

Policy Holder

Employer

Group #

I represent that all information supplied in this application is true and correct. Any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance 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.

Employee Signature

Date