DATROSE
DENTAL PLAN
Enrollment Form

Name: _____

SSN: _____ Date of Birth: _____ Date of Hire: _____

☐ *New Enrollment* ☐ *Cobra Enrollment* ☐ *Change* ☐ *Cancel* Effective Date: _____
(If cancelling coverage, see bottom)

Reason for Change: ☐ *Add Member* ☐ *Remove Member* ☐ *Change Coverage*

Plan (choose one): ☐ Option 1 (High Plan) ☐ Option 2 (Low Plan)

Type (choose one): ☐ Single ☐ Family

Complete for Family Coverage:

Spouse: _____ Date of Birth: _____

Child: _____ Date of Birth: _____ College Student? _____

Child: _____ Date of Birth: _____ College Student? _____

Child: _____ Date of Birth: _____ College Student? _____

Child: _____ Date of Birth: _____ College Student? _____

Are you or any members of your family, covered by another dental plan? ☐ Yes ☐ No

If yes, which family members? _____

_____

What is the name of the other dental insurance provider? _____

Who is your regular dentist? _____ Phone: _____

Address: _____ City: _____ Zip Code: _____

I hereby authorize deductions from my pay for dental insurance:

Signature: _____ Date: _____

Street, City, State Zip: _____ Phone: _____

CANCELLATION:

Reason for cancelling: ☐ Open Enrollment ☐ Qualifying event Please specify: _____

☐ Other Please specify _____

I authorize the cancellation of my dental coverage.

Signature: _____ Date: _____

Entered into ABRA: _____ Sent to ComTon: _____ Initials: _____ Verified by/date: _____

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