



EXECUTIVE DENTAL & VISION



The Dental and Vision Plan Everyone Is Seeing Clearly to Smile About EMPLOYEE ENROLLMENT APPLICATION

Company Name _____ Policy # _____

Effective Date _____ *Note: Effective Date of Coverage Must be First Day of the Month*

OPTION CHOSEN (Select One)

- CAPDENT** (Dentist Selection Required From the CapDent Affiliated Provider List)
 No Deductible
 No Annual Maximum
 No Waiting Period for Major Services
 No Claim Forms
- MANAGED CARE** (Dentist Selection Required From the Managed Care Affiliated Provider List.)
 No Deductible
 No Annual Maximum
 No Waiting Period for Major Services
 No Claim Forms
- Dentist Name _____
 Dentist I.D. # _____
- PPO** (No Dentist Selection Required.)

EMPLOYEE INFORMATION

Last Name _____ First Name _____ Middle Initial _____

Address _____ Apt # _____ City _____ State _____ Zip _____

Home Phone # (____) _____ Work Phone # (____) _____

Social Security # _____ / _____ / _____ D.O.B. ____/____/____ Sex M ___ F ___ Date Employed _____

COVERAGE REQUESTED

Single *Two Party *Family * If Selecting Two Party or Family Coverage Complete Dependent Information Below.

I Refuse Coverage For My Eligible Dependents. YES NO

DEPENDENT INFORMATION

Name of Spouse and Unmarried Dependents	CHECK RELATIONSHIP			BIRTHDATE		
	Spouse	Son	Daughter	Month	Day	Year

Employee Signature **X** _____ Date: ____/____/____

Employer Signature **X** _____ Date: ____/____/____