



DIRECT DENTAL ADMINISTRATORS, LLC
 P.O. BOX 2667
 SAN ANSELMO, CA 94979-2667
 PHONE: 877-878-3384
 FAX: 415-454-2928

Dental Benefit Plan
 Enrollment Application

Please PRINT or TYPE (Press Firmly)

A
PARTICIPANT

First Name		Middle Initial	Last Name		Social Security Number	
Hire Date <u> </u> / <u> </u> / <u> </u> MM DD YYYY		Company Name _____				
Location or Branch _____						
Birth Date <u> </u> / <u> </u> / <u> </u> MM DD YYYY		Sex <input type="checkbox"/> Female <input type="checkbox"/> Male		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Domestic Partner		
Mailing Address _____						
City _____						
State _____		Zip _____		Tel. (____) _____		
Does your spouse have dental plan? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, who is covered? <input type="checkbox"/> Yourself <input type="checkbox"/> Spouse <input type="checkbox"/> Dep. children			Other insurance company name: _____	
Do you have dependent children? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are you enrolling your dependents? <input type="checkbox"/> Yes - Complete section B <input type="checkbox"/> No				

Administration Use Only

Group Number _____

Full-time Part-time

SN _____

B
DEPENDENTS

Spouse			Add/Delete	Sex	Birthdate		
First Name	Middle Initial	Last (if different)		M. F.	MM DD YY		
					/ /		
Child						If child is 19 or older (check one)	
First Name	Middle Initial	Last (if different)				Full-time Students	Disabled
1					/ /		
2					/ /		
3					/ /		
4					/ /		
5					/ /		
6					/ /		
7					/ /		

D CHANGES

PARTICIPANT

Name Change

List new name in section A _____

Former name: _____

DEPENDENT

List new name in section B _____

Reason(s) for change: _____

Effective date of change: _____

 / /

 MM DD YYYY

I authorize the dentist or other health care providers to release to Direct Dental Administrators, LLC., self-insurers, insurance companies, health care service companies or their representatives, any and all information or records (including x-rays) about my medical history, or about services rendered or treatment given to me, that is needed to renew, investigate, or evaluate any claim for benefits.

This authorization shall remain effective for up to five years from this date.

I know I have the right to receive a copy of this authorization if requested.

Signature _____ Date ____/____/____

C
COBRA

Qualifying COBRA event:

<input type="checkbox"/> Termination	<input type="checkbox"/> Divorced	<input type="checkbox"/> Medicare
<input type="checkbox"/> Retirement	<input type="checkbox"/> Widowed	<input type="checkbox"/> Overage dependent
<input type="checkbox"/> Reduction in hours	<input type="checkbox"/> Surviving Dependent	<input type="checkbox"/> Legal Separation
<input type="checkbox"/> Other _____		

Qualifying Date: _____

 / /

 MM DD YYYY

I understand that I may be required by the employer to pay for these benefits.

Signature _____ Date ____/____/____