



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		Company Name			
MM / DD / YYYY		Location or Branch			
Birth Date		Sex	Marital Status		
MM / DD / YYYY		<input type="checkbox"/> Female <input type="checkbox"/> Male	<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?		If yes, who is covered?		Other insurance company name:	
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yourself <input type="checkbox"/> Spouse <input type="checkbox"/> Dep. children			
Do you have dependent children?		Are you enrolling your dependents?			
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes - Complete section B <input type="checkbox"/> No			

Administration Use Only

Group Number _____

BN _____

SN _____

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

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					/ /		

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 ____/____/____