DENTAL APPLICATION AND CHANGE FORM

SUBSCRIBER (EMPLOYEE) INFORMATION

STEP 1

Last Name	First Name	MI
Social Security #	Telephone ( )	
Mailing Address		

City	State	Zip	Employer Name

Is your position covered by a collective bargaining agreement? ❑ Yes ❑ No
If yes, check the appropriate category: ❑ Teacher ❑ Police ❑ Fire ❑ Public Works ❑ Other

Marital Status
❑ Single ❑ Divorced
❑ Married ❑ Legally Separated
❑ Widowed

TYPE OF COVERAGE AND MEMBERSHIP REQUESTED (check)

Dental Type	Dental Membership
Dental Option #________	❑ Single ❑ Two-Person ❑ Family

STEP 2

REASON FOR COMPLETING FORM

❑ New Subscriber
❑ Benefit Change/Open Enrollment/Transfer
❑ Name Change
❑ Marriage
❑ Birth/Adoption
❑ Death
❑ Divorce/Legal Separation
❑ Dependent Now Eligible
❑ Dependent No Longer Eligible
____
Dependent Name
❑ Retirement
❑ Election of COBRA Coverage
❑ Spouse's Employment Change
❑ Other (explain)________
Actual Date of Event________

HealthTrust Office Use Only

SUBSCRIBER AND DEPENDENT INFORMATION (Complete this section as your membership should appear)

STEP 3

NAME (First, MI, Last)	Date of Birth Month/Day/Year	Relation to Subscriber	Gender M/F	Student Over 19	Disabled
Employee Name	__/__/__	Self			
Spouse Name	__/__/__	Spouse			
Dependent Name**	__/__/__			❑	❑
Dependent Name**	__/__/__			❑	❑
Dependent Name**	__/__/__			❑	❑

**If your dependent(s) is/are age 19 or older, complete the form attached to the back of this application.

OTHER DENTAL INSURANCE COVERAGE INFORMATION

STEP 4

Do you or your family have dental coverage through another group or employer? ❑ Yes ❑ No	Name of Insurance Company
Are you or another dependent transferring coverage from another dental carrier? ❑ Yes ❑ No	Policy Number
Member Name	Effective Date Termination Date

SUBSCRIBER SIGNATURE

STEP 5

I hereby authorize HealthTrust and my employer to institute the action(s) indicated on this form. If my employer requires a contribution for this coverage, this authorizes the appropriate payroll deductions. I understand that the effective date and termination date of my membership will be determined by HealthTrust and my employer in accordance with the plan rules. I understand that I must sign this form for claims to be processed. By signing this application, I attest to the accuracy and truthfulness of this information and will provide documentation to HealthTrust upon request.

Subscriber Signature________________ Date __/__/__

EMPLOYER USE ONLY

STEP 6

Date of Hire __/__/__ | Date of Rehire __/__/__ | ❑ Full-Time | ❑ Part-Time to Full-Time | ❑ Part-Time Number of Hours Weekly____ | ❑ COBRA | ❑ Retiree

Eligibility Organization Name	Employee Job Title
Dental Group/Carrier Number Effective Date of Coverage __/__/__	Benefits Administrator Signature/Stamp Date __/__/__

Form #HT037
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White - HealthTrust Yellow - Employer Pink - Employee

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