EMPLOYEE ENROLLMENT

FREEDOM DENTAL PLANS™

EMPLOYER NAME: _____

SUBSCRIBER'S INFORMATION

LAST NAME	FIRST NAME	MI	SS#

ADDRESS	APT #

CITY	STATE	ZIP

GENDER	DATE OF BIRTH	RACE	ETHNICITY	PREFERRED SPOKEN LANGUAGE:

HOME PHONE	WORK PHONE	HIRE DATE	EFFECTIVE DATE

COVERAGE SELECTION – Please verify with your employer which plans are available.

Freedom Plan Choice: PrePaid DHMO | *PPO EPO $1,000 $1,500 $2,000 $2,500

Please circle your plan selection

*PPO Network Selection: _____

If nothing is written, a default will be assigned.
DHMO network is Western Dental and EPO network is First Dental Health.

DEPENDENT INFORMATION

RELATIONSHIP	LAST NAME	FIRST NAME	MI	GENDER	DATE OF BIRTH	RACE	LANGUAGE	Social Security Number	DENTAL OFFICE #

COORDINATION OF BENEFITS: Does any person on this application intend to continue other group dental coverage? Yes No

If yes, name of person: _____Insurance Company: _____

WAIVER OF COVERAGE

I have been given the opportunity to apply for group coverage, but I am waiving the dental benefits, due to the following:

- ☐ I am covered under a spouse or domestic partner's plan.
- ☐ I choose not to elect coverage at this time
- ☐ I choose not to elect coverage at this time for my spouse
- ☐ I choose not to elect coverage at this time for my child(ren)

_____ _____ _____

Subscriber's Name (Please Print) Signature Date

CA INS LIC #0M76879
TX INS LIC #2989289