# UNIVERSAL DENTAL APPLICATION

| **County of Union** | *Effective Date of Coverage:* | *Group Number:* |
|---|---|---|

**General Information – This Section to be Completed By all Applicants – Please Print Clearly**

| *Last Name* *First Name* *Middle Initial* | *Phone #* ( ) | *Male* ☐ *Female* ☐ | *Married* ☐ *Single* ☐ |
|---|---|---|---|
| *Street Address* | *Date of Birth* | | |
| *City* *State* *Zip Code* | *Social Security Number* | | |

**Dependent Information – List Spouses and Unmarried Children to 23 years of age.**

| *Name of Dependent* | *Relationship* | *Date of Birth* | *Social Security Number* |
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**For Healthplex Applicants Only:**

*From the list of participating Dental Centers provided by Healthplex/Eastern Dental, select your dental care location and enter the name and Site ID number.*

_____ _____

*Dental Center* *Site ID Number*

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**For Delta Care Flagship Plan Applicants Only:**

| *First Choice of Dentist/Dental Center from Participating Flagship Dental List* | *Location Code Number* |
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| *Second Choice of Dentist/Dental Center from Participating Flagship Dental List* | *Location Code Number* |

*Optional choices will be selected if a provider terminates his/her participation agreement with Flagship. I authorized release to Flagship Health System of all my treatment information as a DeltaCare subscriber and the treatment information of my dependents.*

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*I hereby attest that all information furnished is true and complete to the best of my knowledge and authorize my employer to make any required payroll deductions.*

**_____ I DO NOT WISH TO PARTICIPATE IN ANY OF THE COUNTY OF UNION SPONSORED DENTAL PLANS FOR EMPLOYEES**

Signature:_____Date:_____