

UNIVERSAL DENTAL APPLICATION

County of Union	<i>Effective Date of Coverage:</i>	<i>Group Number:</i>
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General Information – This Section to be Completed By all Applicants – Please Print Clearly

<i>Last Name</i>	<i>First Name</i>	<i>Middle Initial</i>	<i>Phone # ()</i>	<i>Male</i> <input type="checkbox"/>	<i>Married</i> <input type="checkbox"/>
				<i>Female</i> <input type="checkbox"/>	<i>Single</i> <input type="checkbox"/>
<i>Street Address</i>			<i>Date of Birth</i>		
<i>City</i>	<i>State</i>	<i>Zip Code</i>	<i>Social Security Number</i>		

Dependent Information – List Spouse and Unmarried Children under the age of 23.

Relation	Change Type	Dependent Name (Last Name, First Name MI)	Gender	Date of Birth
Spouse	<input type="checkbox"/> Add <input type="checkbox"/> Remove		<input type="checkbox"/> Male <input type="checkbox"/> Female	____/____/____
Child	<input type="checkbox"/> Add <input type="checkbox"/> Remove		<input type="checkbox"/> Male <input type="checkbox"/> Female	____/____/____
Child	<input type="checkbox"/> Add <input type="checkbox"/> Remove		<input type="checkbox"/> Male <input type="checkbox"/> Female	____/____/____
Child	<input type="checkbox"/> Add <input type="checkbox"/> Remove		<input type="checkbox"/> Male <input type="checkbox"/> Female	____/____/____
Child	<input type="checkbox"/> Add <input type="checkbox"/> Remove		<input type="checkbox"/> Male <input type="checkbox"/> Female	____/____/____

For Healthplex Applicants Only:

<i>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.</i>	
_____	_____
<i>Dental Center</i>	<i>Site ID Number</i>

For Delta Care Flagship Plan Applicants Only:

<i>First Choice of Dentist/Dental Center from Participating Flagship Dental List</i>	<i>Location Code Number</i>
_____	_____
<i>Second Choice of Dentist/Dental Center from Participating Flagship Dental List</i>	<i>Location Code Number</i>
_____	_____

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.

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.

Decline Coverage

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

Signature: _____ Date: _____