Dental Plan Enrollment Form

FOR DENTAL PLANS BY DENTCARE DELIVERY SYSTEMS, INC., INTERNATIONAL HEALTHCARE SERVICES, INC., HEALTHPLEX INSURANCE COMPANY, OR HEALTHPLEX, INC.

Employee Information

Last Name	First Name	M.I.	SSN/ID Number

Address	City	State	Zip Code

Home Phone	Work Phone	Gender	D.O.B.

Employer Name/Group	Group Number	Effective Date	Date of Hire

Other Dental Coverage: ☐ NO ☐ YES	Name of Other Plan (if applicable):

Group Plan Selection

- ☐ **CapDent New York**
- ☐ **CapDent New Jersey**
- ☐ **CapDent Plus New York**
- ☐ **CapDent Plus New Jersey**
  - ☐ **Primary** ☐ **EPO**
- ☐ **CapDent Plus Ultra**
- ☐ **Preferred Choice Plan**
- ☐ **CapDent Select**
- ☐ **CapDent Select Plus**
- ☐ **Omni PPO**
- ☐ **Healthplex Insurance Company Plan**
- ☐ **Comprehensive Voluntary**
  - ☐ **Low Option**
  - ☐ **Medium Option**
  - ☐ **High Option**
  - ☐ **High Enhanced Option**

Coverage Selected

☐ **Single** ☐ **Two Party** ☐ **Family**

Dental Selection

Dentist Name	Dentist Site Code

For Managed Care Plans - Please choose one Primary Care Dentist from the CapDent Directory - One Per Family

Dependents To Be Covered (Spouse, Domestic Partner & unmarried dependent children) * If your child is over the age of 18, you must submit student documentation.

Last Name, First Name	M/F	Spouse/D.P.	Son	Dtr	D.O.B.
Last Name, First Name	M/F	Spouse/D.P.	Son	Dtr	D.O.B.
Last Name, First Name	M/F	Spouse/D.P.	Son	Dtr	D.O.B.
Last Name, First Name	M/F	Spouse/D.P.	Son	Dtr	D.O.B.
*Last Name, First Name	M/F	Spouse/D.P.	Son	Dtr	D.O.B.
*Last Name, First Name	M/F	Spouse/D.P.	Son	Dtr	D.O.B.

***There is an additional monthly premium of $10.00 for each family member in excess of five (5).**

Signature	Date

Broker Information

Broker Name	SSN/Tax ID #

Any person who includes any false or misleading information on an application for an Insurance Policy is subject to criminal and civil penalties.

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"PLEASE PRINT OR TYPE ALL INFORMATION"