



P.O. Box 8510 * St. Louis, MO 63126

New Enrollment/Change Form

Ph. (314) 543-4900 or (800) 501-3471

Fax (314) 849-4830 or (800) 501-8432

eligibility@essexdental.com

| | | | | | |
|--------------------------|------------------|------------------------|-----------------------------|--|--|
| Group Name: _____ | | | | | |
| Part I: Reason | | | | Part II: Provider Panel | |
| Birth of Child | Custody of Child | Loss of Other Coverage | Retired | Essex Dental Benefits Connection Dental | |
| COBRA | Death | Marriage | Termination | | |
| Coverage Type | Divorce | New Enrollment | Waive Coverage ¹ | | |
| Other _____ | | Date of Change _____ | | | |

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|---------------------------------------|--------------|--------|---------|--------------|-------------|--|--|
| Part III: Employee Information | | | | | | | |
| 1. Social Security No. | 2. Last Name | First | MI | 3. Birthdate | 4. Gender | | |
| 5. Street Address | | Apt. # | 6. City | 7. State | 8. Zip Code | | |

| Part IV: Dependent Information | | | | | | | | |
|---------------------------------------|--------|------------|----|---------------------|---------------------|-----------|--------|--------------|
| Add | Delete | First Name | MI | Last (if different) | Social Security No. | Birthdate | Gender | Relationship |
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|---------------------------|--------------|--|--|--|-----------------------------------|
| Part V: Enrollment | | Part VI: Coverage Type | | Part VII: Product Type and Level (if applicable) | |
| 1. Effective Date | 2. Hire Date | <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + Dependent(s) | <input type="checkbox"/> Employee + 1 <input type="checkbox"/> Family | <input type="checkbox"/> EPO <input type="checkbox"/> Indemnity <input type="checkbox"/> PPO | Option 1 (High) Option 2 (Low) |
| 3. Group Name | | | | | |

| | | | | | |
|---|--|-------------------|----|---------------------|-------------------------|
| Part VIII: Other Benefit Information | | | | | |
| 1. Do you have current orthodontic coverage? | | Yes | No | | |
| 2. Are you or any of your dependents enrolled in another dental benefit program? | | Yes | No | 2a. Subscriber Name | 2b. Social Security No. |
| 2c. Carrier Name | | 2d. Carrier Phone | | 2e. Carrier Address | |
| 3. Are you or any of your dependents covered by another member under one of our benefit programs? | | Yes | No | 3a. Member's Name | 3b. Social Security No. |

Part IX: Authorization

I have read the plan provisions provided by my employer and Essex Dental Benefits.

I authorize payment of dental benefits to the provider of my dental care and payroll deductions to cover my share, if any, of the dental premium.

I also authorize any dentist or provider of my dental care to release any information pertaining to my dental treatment to Essex Dental Benefits.

I certify that the above information is true and correct and authorize the processing of this form as indicated.

Employee Signature _____ Date _____ E-mail² _____

Employee: Please return this form to your Human Resources Department.
Human Resources Department: Please mail this form to Essex Dental Benefits, P.O. Box 8510, St. Louis, MO 63126-0510 or fax it to (314) 849-4830 or (800) 501-8432.

| For Essex Dental Benefits Use Only | | | |
|---|--------------|------------|-------------------|
| Effective Date | Date Entered | Entered By | ID Card Requested |
| | | | |

¹ Opt-out and late entrant limitations apply.
² For use by Essex Dental Benefits ONLY to communicate account and product updates.