



THE DENTAL NETWORK

"Plans to Make You Smile - Now and Into the Future"

UNDERWRITTEN BY:
Colorado Bankers Life Insurance Company

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Baltimore, Maryland 21224
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ADMINISTERED BY:
The Dental Network, Inc.

DENTAL ENROLLMENT FORM

Employee, please print or type. Complete all areas, sign and date.
Do not write in shaded areas.

Name (last, first, middle initial)		FOR OFFICE USE ONLY	Group No. _____
			Eligibility Date _____
Home Address (street)		Date of Birth	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
City	State	Zip	Home Telephone ()
			Business Telephone ()
Your Employer	Employer Address (street, city, state, zip code)		
		Social Security Number (Required)	
		- -	

Spouse Information - Complete only if spouse is to be covered.

Name of Spouse (first, middle initial)(Last - only if different)	Is your spouse covered under any other dental Plan?	Date of Birth	Sex
	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Male <input type="checkbox"/> Female

Dependent Children - List only those children to be covered.

Name (first, middle initial)(last only if different)	Date of Birth	Relationship	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Check if over age 19 <input type="checkbox"/> Full time student <input type="checkbox"/> Handicapped child	Name of accredited school
			Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Check if over age 19 <input type="checkbox"/> Full time student <input type="checkbox"/> Handicapped child	
			Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Check if over age 19 <input type="checkbox"/> Full time student <input type="checkbox"/> Handicapped child	
			Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Check if over age 19 <input type="checkbox"/> Full time student <input type="checkbox"/> Handicapped child	
			Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Check if over age 19 <input type="checkbox"/> Full time student <input type="checkbox"/> Handicapped child	

<input type="checkbox"/> Initial Enrollment	<input type="checkbox"/> Policy Change
<input type="checkbox"/> EMPLOYEE	Reason for change in coverage:
<input type="checkbox"/> EMP/CHILD(REN)	1. ___ Married 4. ___ Birth/Adoption
<input type="checkbox"/> EMP/SPOUSE	2. ___ Widowed 5. ___ Address Change
<input type="checkbox"/> FAMILY	3. ___ Divorced 6. ___ Other

I authorize my employer to deduct from my pay any premium required of me toward the cost of elected dental coverage.

I agree on behalf of myself and any dependent(s) named above to provide Colorado Bankers Life Insurance Company or its appointed representative with information to process this enrollment form or to administer eligible benefits.

Employee's signature _____

Date _____