American Dental Plan of Wisconsin, Inc.

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FOR ADP USE ONLY
Subscriber #
GRP#
Effective Date
Plan #

SUBSCRIBER APPLICATION FOR DENTAL INSURANCE

Applicant's Name (Last, First, Middle) (Please Print)	Position	
Street Address	City, State	Zip Code
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed	Your Social Security Number	Phone Numbers Home: Work:

Name of Group - Employer:	City	Division (for billing purposes only)	Date Employed

REASON FOR SUBMITTING APPLICATION (Check appropriate Box or Boxes)

☐ Initial Enrollment
☐ Change to Single
☐ Date ____________
☐ Change to Family
Date ____________

☐ Adding Dependent
☐ Deleting Dependent
☐ Marital Status Change
Date ____________
☐ Married ☐ Divorced
☐ Widowed ☐ Separated
☐ Waive Coverage

☐ Continuation:
Explain: ____________
☐ Open Enrollment
Effective Date ____________
☐ Name Change - Former
Name ____________
☐ Other ____________

COVERAGE DESIRED: ☐ Single (Emp. Only) ☐ Double (Emp. + One) ☐ Family (Emp., Sps. + Elig. Dep.)

LIST ALL PERSONS TO BE INCLUDED IN THIS APPLICATION - INCLUDING YOURSELF

Last Name (If Other Than Applicant's)	First Name and Middle Initial	Member Number	Date of Birth			Sex	Selected Primary Dentist	Office Use DDS #
			Mo.	Day	Year			
(Employee)								
(Spouse)								
(Dependents)								

PLEASE ANSWER THE FOLLOWING QUESTIONS

AMER. DENTAL PLAN REQUIRES MEMBERS TO BE COVERED BY HEALTH INSURANCE TO BE ELIGIBLE FOR DENTAL COVERAGE.

1. Are you covered by a health insurance policy? ☐ Yes ☐ No
   If Yes: Name of Insured ____________ Employer ____________ Ins. Company ____________
   Subscriber # ____________ Group # ____________
   Ins. Co. Address ____________
2. Are the dependents named above chiefly dependent upon you or another parent for support and maintenance?
   ☐ Yes ☐ No
   If any dependent children are over age 19, are they full-time students? ☐ Yes ☐ No
   If Yes: Dependent Name ____________ Name of School ____________
   If No: Are they physically/mentally disabled? ☐ Yes ☐ No

I HEREBY APPLY FOR ENROLLMENT SUBJECT TO THE TERMS AND CONDITIONS OF THE MASTER GROUP CONTRACT

Signature ____________

Date ____________

EMPLOYER REPRESENTATIVE APPROVING APPLICATION

Signature ____________

Date ____________