



# Enrollment

PLEASE PRINT CLEARLY WHEN FILLING OUT THIS FORM

## EMPLOYER INFORMATION

(To be entered by company representative)

Company Name: Cultural Alliance

Date of Hire: \_\_\_\_\_

Address: \_\_\_\_\_

Employee Status:  Hourly  
 Salaried  
 Retired

City: Washington State: DC Zip Code: 20005

## EMPLOYEE INFORMATION

(To be entered by employee)

Employee Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Marital Status:  Single  
 Married

**WAIVER OF ENROLLMENT:**  I elect *not* to participate in the plan at the present time.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## PLAN OPTIONS

**Select Plan Options** (please circle one):

DenexPlus Excel MAC

**Requested Level of Coverage:**

Employee Only  
 Employee & Spouse  
 Employee & Child(ren)  
 Family

## PERSON(S) COVERED:

Last Name	First Name	MI	Sex	DOB	SSN	Relation	Student*
Employee							
Dependents							

\*If a dependent is over age 19, you must submit proof of full-time enrollment at an accredited school or university.

The applicant represents that he/she has read each question and that the answers are complete and true to the best of his/her knowledge or belief.

The proposed rates shall take effect as of the requested effective date if this application is accepted. In the event that the application is not accepted, any premium advances shall be refunded.

*Any person who knowingly and with intent to defraud any insurance company, or other person, files an application for insurance or statement of claim containing any material false information, or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.*

**Enrollee Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

Plans underwritten by Group Dental Service of Maryland, Inc; 111 Rockville Pike, Suite 950; Rockville, MD 20850