City of Titusville Dental Benefit Plan

Preferred BENEFIT ADMINISTRATORS INCORPORATED
PO BOX 916188, LONGWOOD, FL 32791-6188

☐ **Enrollment Application** **Effective Date:** _____ **Group: 392**

Employee Name: _____ **Member ID #:** _____
(Will be assigned by Claims Administrator)

Mailing Address: _____, _____, ____, _____, (___)_____
Address City St. Zip Code Phone #

Date of Full-Time Employment: _____ **Date of Birth:** _____ **Gender:** ☐ **M /** ☐ **F**

Title: _____ **E-Mail Address:** _____ **Social Security #:** _____
(SSN will be used for federal reporting & identification purposes only)

Dental Plan Enrollment:

☐ **Employee Only** ☐ **Employee & Spouse** ☐ **Employee & Child(ren)** ☐ **Employee & Family** ☐ **Waive Dental Coverage** (Reason: _____/ Signature: _____)

COMPLETE DEPENDENT INFORMATION ONLY IF YOU WANT FAMILY COVERAGE *LIST LEGAL DEPENDENTS ONLY*				
Full Name of Dependent	Date of Birth	Gender	Relationship to Employee	Social Security # (Required)

☐ **Change Application** **Effective Date:** _____

Employee Name: _____ **Member ID #:** _____

☐ **Name Change:** _____
Previous Name

☐ **Address Change:** _____
New Street Address City State Zip Code

Change Dental Coverage To:

☐ **Employee Only**
☐ **Employee & Spouse**
☐ **Employee & Child(ren)**
☐ **Employee & Family**
☐ **Cancel Dental Coverage**

Reason for Dental Coverage Change:

☐ **Marriage or divorce (date: _____)**
☐ **Birth or adoption of child (date: _____)**
☐ **Death of spouse or child (date: _____)**
☐ **Loss of dental coverage due to eligibility (date: _____)**
☐ **Exhaustion of COBRA benefits (date:_____)**
☐ **Other (Explain)**_____

COMPLETE ONLY IF YOU WANT TO ADD / DELETE FAMILY MEMBERS *LIST LEGAL DEPENDENTS ONLY*						
Add	Delete	Full Name of Dependent	Date of Birth	Gender	Relationship to Employee	SSN (if adding Dep.)

Is there any other Group Dental Plan coverage in force? __NO (If No, Skip A. through C.) __YES (If Yes, Complete A. Through C.)

A. Insurance Co. or Dental Plan Name: _____ **Group #:** _____ **Phone #:**_____

B. Employer through which other coverage is held (if any): _____

C. Name of Policyholder: _____ **Eff. Date:** _____ **Single Coverage__ or Family Coverage___**

Unless otherwise indicated, I hereby request the Group Dental Benefits to which I am or may be entitled and authorize required deductions towards the cost, if applicable. I further authorize any dentist, dental practitioner, insurance company or employer having dental information about me or my covered dependents which relates to the diagnosis and treatment of any illness or injury to release this information to Preferred Benefit Administrators, Inc. This authorization shall remain in effect as long as I remain covered by the plan.

_____

Employee Signature **Date**