# MADA DENTAL PLAN
## MEMBER ENROLLMENT FORM

Name of Employee: (Last, First, MI)_______________________________________________________________

SSN: ________________________________ DOB: ________________________ Male Female

JOB TITLE: __________________________________________FULL-TIME HIRE DATE: ___________________

Name of Employer: ______________________________________________________________ DIV #: _______

**Your Home Address**: _____________________________________________________________________

City: ______________________________State: ____ Zip: _______ Home Phone: _______________________

Work Phone: __________________________________ Fax Number: _________________________________

**TYPE OF COVERAGE ELECTED:**

I am enrolling in the ____ **GOLD** Plan _____ **PLATINUM** Plan

Employee Only Employee + 1 Employee + 2 FAMILY

**Please provide the following information for each dependent to be insured:**

Name: _________________________ SSN: ________________ DOB:_____________ Relationship: __________

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Name: _________________________ SSN: ________________ DOB: ____________ Relationship: __________

**I decline coverage.** I understand that I will not be allowed to enroll in this dental program at a later date, unless special enrollment conditions apply or at open enrollment.

Do you have any other Dental Insurance? (Circle) **Yes** **No**
If yes, Please Specify: ____________________________________________________________________________

Does your spouse work? If so, please complete the following:
Name of Spouse's Employer: __________________________________________________________________
Address: _______________________________City: ______________________ State: ____ Zip Code: ______
Telephone #_____________________________

You are not covered under this plan until this form is submitted to MADA. Please return it to your department head or to personnel.

Date: ____________________________Signature: ____________________________________________________

EFFECTIVE DATE: __________________________ TERMINATION DATE: _________________________