CarePlus

DENTAL ENROLLMENT FORM

INSTRUCTIONS

1) Fill Out Completely
2) Choose a Dental Office
3) Print Firmly & Legibly
4) Sign and Date this Form
5) Use Pink Copy as Your Temporary I.D.
6) Read Terms and Conditions on Reverse Side

FOR EMPLOYER USE ONLY		
EFFECTIVE DATE OF BENEFITS		
MO.	DAY	YEAR

EMPLOYER	DATE FIRST WORKED	CONTRACT DESIRED ☐ SINGLE ☐ FAMILY ☐ E+SP ☐ E+CHILD(REN)

	LAST NAME	FIRST NAME	MIDDLE INITIAL	SEX	DATE OF BIRTH MO	DAY	YEAR	SOCIAL SECURITY NO.
	EMPLOYEE							
	SPOUSE							
DEPENDENT CHILDREN								

HOME ADDRESS	PRIMARY PHONE
CITY STATE ZIP	SECONDARY PHONE

Select a Dental Center

- ☐ **Appleton** 4660 W. College Ave.
- ☐ **Appleton - North** 2115 E. Evergreen Dr.
- ☐ **Fond du Lac** 545 E. Johnson St.
- ☐ **Franklin** 6855 S. 27th St.
- ☐ **Green Bay** 430 Main St.
- ☐ **Green Bay - Howard** 2340 Duck Creek Pkwy.
- ☐ **Greenville** N1737 Lily of the Valley Dr.
- ☐ **Kenosha** 7117 Green Bay Rd.
- ☐ **Milwaukee - Beerline B** 220 E. Pleasant St.
- ☐ **Milwaukee - Downtown** 205 E. Wisconsin Ave.
- ☐ **Milwaukee - South** 1135 S. Cesar Chavez Dr.
- ☐ **Sturtevant** 10155 Washington Ave.
- ☐ **Waukesha** 1211 Dolphin Ct.
- ☐ **Wauwatosa** 11711 W. Burleigh St.

I HEREBY APPLY FOR ENROLLMENT SUBJECT TO THE TERMS AND CONDITIONS ON REVERSE SIDE.

SIGNATURE **X**_____ DATE SIGNED _____

CP-401EF
0616

WHITE & YELLOW COPIES to Employee Benefits Department
PINK COPY - Retain for your files.

TERMS AND CONDITIONS

1. All statements and answers in this application are representations made by the member on behalf of himself/herself and other persons named in the application, if any, to induce the insurance of the dental contract applied for.

2. The Applicant, on behalf of himself/herself and other persons named in the application, if any, consents, authorizes and directs any physician, dentist, consultant, hospital or other person or corporation by whom or in which any diagnosis, medical, surgical or dental treatment or advice is being, shall be or shall have been rendered to furnish and make available to Care-Plus Dental Plans, Inc., all such medical, surgical and dental reports, records and other information as they may request, at no cost to them.

3. The contract applied for will become effective only upon the acceptance of this application by Care-Plus Dental Plans, Inc. to be evidenced by the insurance of Identification Card(s) which will be delivered to the Group or to the Member designated herein as the Applicant.

4. The member authorizes the Group as his remitting agent to deduct from his wages or salary a sufficient amount to provide for the regular and timely prepayment of the prevailing subscription fees that are not otherwise contributed for the contract applied for, and to remit the same for him and on his behalf to Care-Plus Dental Plans, Inc. as specified in the agreement between Care-Plus Dental Plans, Inc. and the Group.