



**New Enrollment/Change Form**

Ph. (314) 543-4900 or (800) 501-3471

Fax (314) 849-4830 or (800) 501-8432

marketing@essexdental.com

P.O. Box 8510 \* St. Louis, MO 63126

**Group Name:**

<b>Part I: Reason</b>				<b>Part II: Provider Panel</b>	
Birth of Child	Custody of Child	Loss of Other Coverage	Retired	Connection Dental	
COBRA	Death	Marriage	Termination	Essex Dental Benefits	
Coverage Type	Divorce	New Enrollment	Waive Coverage*	<b>Part III: Orthodontic Coverage</b>	
Other _____	Date of Change _____			Yes	No

**Part IV: Employee Information**

1. Social Security No.	2. Last Name	First	MI	3. Birthdate	4. Gender
5. Street Address	Apt. #	6. City	7. State	8. Zip Code	

**Part V: Dependent Information**

Add	Delete	First Name	MI	Last (if different)	Social Security No.	Birthdate	Gender	Relationship

**Part VI: Enrollment**

**Part VII: Coverage Type**

**Part VIII: Product Type and Employer**

1. Effective Date	2. Hire Date	Employee Only	Employee + 1	EPO	COBRA	Med - Fellows
3. Group Name		Employee + Spouse	Family	Indemnity	Hilltop	Retirees
		Employee + Dependent(s)		PPO	Med School	WUBJ - Clinical

**Part IX: Coordination of Benefits**

1. Are you or any of your dependents enrolled in another dental benefit program?		1c. Carrier Name	1d. Carrier Phone
1a. Subscriber Name	1b. Subscriber Social Security No.	1e. Carrier Address	
2. Are you or any of your dependents covered by another member under one of our benefit programs?		2a. Member's Name	2b. Member ID

**Part X: Authorization**

I have read the plan provisions provided by my employer and Essex Dental Benefits.  
 I authorize payment of dental benefits to the provider of my dental care and payroll deductions to cover my share, if any, of the dental premium.  
 I also authorize any dentist or provider of my dental care to release any information pertaining to my dental treatment to Essex Dental Benefits.  
 I certify that the above information is true and correct and authorize the processing of this form as indicated.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

**Employee: Please return this form to your Human Resources Department.**  
**Human Resources Department: Please mail this form to Essex Dental Benefits, P.O. Box 8510, St. Louis, MO 63126-0510 or fax it to (314) 849-4830 or (800) 501-8432.**

**For Essex Dental Benefits Use Only**

Effective Date	Date Entered	Entered By	ID Card Requested
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\* Opt-out and late entrant limitations apply.