

Mail forms to:
 Pro Benefits Administrators
 100 Corporate Pkwy, Suite 334
 Amherst, New York 14226
 Phone: 888-683-3682



**DENTAL INSURANCE
 ENROLLMENT AND CHANGE FORM**

Underwritten by:
 Presidential Life Insurance Co.

Part A – Enrollment Information

1. Policyholder Name (Company Name)	2. Division	3. Effective Date:
4. Policyholder Street Address	5. Hire Date	6. Gender (<i>check one</i>) <input type="checkbox"/> Male <input type="checkbox"/> Female
7. Employee's Name (Last, First, MI) <input type="checkbox"/> Mr. <input type="checkbox"/> Miss <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	8. Birth Date	9. SS#
10. Employee's Address (Incl. Apt. No.): Address: _____ City: _____ State _____ Zip Code _____	11. Check One: <input type="checkbox"/> New Applicant <input type="checkbox"/> Change <input type="checkbox"/> COBRA Eff. Date: _____	
	12. Home Phone	
	13. Coverage Requested <input type="checkbox"/> SINGLE <input type="checkbox"/> EE + SPOUSE <input type="checkbox"/> EE + CHILD <input type="checkbox"/> FAMILY (EE, SPSE & CHILD)	
14. Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated <input type="checkbox"/> Divorced		

Part B – Dependent Information

15. Give the following information for each dependent to be insured: Name (Last, First, MI)	Relationship	Sex	Birth Date	Full-Time Student
1.		<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No
2.		<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No
3.		<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No
4.		<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No
5.		<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No
6.		<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No

Are any dependent children adopted? Yes No If "Yes", indicate name and date of adoption: _____

Have you included step-children as dependents? Yes No If "Yes", indicate name is: _____

Do your step-children reside with you? Yes No
 Are they dependent upon you for support and maintenance? Yes No

Are any of your children handicapped? Yes No If "Yes", indicate name is: _____

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 materially 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

X _____
 Signature of Employee

 Date