Dental Benefit Enrollment & Change Form

Employers Dental Services

Principal®

Contract number | Effective Date

- ☐ New Enrollment
- ☐ Cancel coverage
- ☐ COBRA enrollment
- ☐ Change address (complete sections 1, 2, 3, 9)
- ☐ Add dependent(s) (complete sections 1, 2, 9, 11)
- ☐ Delete dependent(s) (complete sections 1, 2, 9, 11)
- ☐ Name change (complete sections 1, 2, 9)
  Former name:
- ☐ Change dental office (complete sections 1, 2, 3, 4, 9)

(1) Employer/ Company name | Date employed | (7) Home telephone

(2)Your name (last, first, middle initial) | (8) Work telephone

(3) Mailing address, city | ZIP Code | (9) Social security number

(4) Dental office selection for you and your enrolled dependents:
ID number: | Name of office: | (10) Date of birth

(5) Total number of dependents you are enrolling | (6) Your email address | Sex
☐ Male ☐ Female ☐ Non-binary

(11) List all eligible dependents you wish to enroll: Attach additional cards if necessary

	Last name (if different)	First name	Middle initial	Date of birth
Spouse				
Child				
Child				
Child				
Child				

Eligibility: You may be able to elect coverage for eligible dependents. See your employer for details on the definition of eligible dependent. All newly eligible dependents must be added within 31 days of change. Dependent children must be removed from enrollment when they are no longer eligible.

Benefits are available at an EDS contracted dental facility ONLY.

I hereby apply for coverage under EMPLOYERS DENTAL SERVICES for which I am now entitled or may become entitled under the provisions of the Master Agreement. I authorize deductions from my earnings at the required contributions toward the cost of the coverage. I certify that I am eligible to participate and that the above information is correct. I authorize any dentist or other dental care provider to furnish any representative of Employers Dental Services any and all records pertaining to dental history, services, or treatment of anyone enrolled for purposes of review, investigation, or evaluation of an application or claim. A photocopy of this authorization shall be valid as the original. This authorization shall remain valid for so long as my coverage remains in force. My authorized representative or myself are entitled to receive a copy of the authorizations form.

Date _____ Signature _____

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