Redwood Health Services

Enrollment Application for Dental Coverage

Return this form to the Fund Office.

Employee Information

Social Security Number:	Date of Birth:	Date of Hire:	Gender	Coverage
			☐ M ☐ F	☐ Dental

Last Name	First Name	MI

Home Address:

City: | State: | Zip Code:

Home Phone: | Work Phone:

Mailing Address (if different from home):

Employer Use Only

☐ Add ☐ Termination ☐ Other

Group Number	Effective Date			Employer (Name of Company)
	MONTH	DAY	YEAR	

Employment Status	Date of Hire				COBRA Effective Date:		
☐ Actively Employed ☐ Retired	MONTH	DAY	YEAR	☐ Initial Enrollment ☐ COBRA Continuation ☐ 18 months ☐ 36 months	MONTH	DAY	YEAR

List below: All dependents covered by this enrollment. Only your spouse and eligible unmarried dependents may be included.

Social Security Number:	Last Name:	First Name:	MI	Relationship	Date of Birth	Gender	FT Student
						☐ M ☐ F	☐ Y ☐ N
						☐ M ☐ F	☐ Y ☐ N
						☐ M ☐ F	☐ Y ☐ N
						☐ M ☐ F	☐ Y ☐ N
						☐ M ☐ F	☐ Y ☐ N
						☐ M ☐ F	☐ Y ☐ N

If eligible family members are covered by other dental insurance, please so indicate.

Are you or any of your dependents currently covered by another dental plan? ☐ Yes ☐ No

If yes, name of the employee covered on the other policy:

Name(s) of the family member(s) covered on the other policy:

Name of the insurance company:	Name of the employer:
Effective date:	SS# of the policyholder:

I represent that the above information is true and that I meet the REEW Health and Welfare Plan rules as may be required to maintain my eligibility including my dependents eligibility (if any).

Signature:_____ Date:_____