P.R.I.M.E. Benefit Systems, Inc.
P.O. Box 2239
Cedar Rapids, IA 52406-2239
319-393-2005/800-473-8970
319-395-7498 (FAX)

DENTAL APPLICATION
ENROLLMENT AND CHANGE FORM

IS THIS APPLICATION: ❑ New ❑ Change

EMPLOYER	DEPT NO.	EMPLOYEE NO.
54 College Community School District		

DATE OF HIRE		MARITAL STATUS	SEX
EFFECTIVE DATE		❑ SINGLE ❑ MARRIED	❑ MALE ❑ FEMALE

NAME	SOCIAL SECURITY #	BIRTHDATE

STREET	CITY	STATE	ZIP

E-MAIL ADDRESS	PHONE/TEXT MESSAGE NUMBER

THIS REQUEST FOR COVERAGE IS FOR:
❑ Single ❑ Employee + 1 ❑ Family ❑ NO COVERAGE

PLEASE LIST ELIGIBLE DEPENDENTS BELOW:

NAME	SOCIAL SECURITY #	BIRTHDATE MO.	BIRTHDATE DAY	BIRTHDATE YR.	SEX
SPOUSE					❑ Male ❑ Female
CHILD					❑ Male ❑ Female
CHILD					❑ Male ❑ Female
CHILD					❑ Male ❑ Female
CHILD					❑ Male ❑ Female

OCCURANCES AFFECTING CONTRACT BENEFITS	NAME OF AFFECTED PARTY	DATE OF EVENT
❑ MARRIED ❑ DIVORCE ❑ BIRTH ❑ DEATH ❑ OTHER please explain:_____		

COORDINATION OF BENEFITS WITH SPOUSE'S DENTAL INSURANCE (IF APPLICABLE)

If your spouse or anyone named on this application has dental insurance through another company where the employer pays any portion of the cost or makes payroll deductions, please complete the following:

	EFFECITVE DATE
NAME	EMPLOYER
INSURANCE COMPANY NAME	POLICY # WITH INSURANCE COMPANY
INSURANCE COMPANY ADDRESS	CONTRACT TYPE ❑ Single ❑ Family

I HEREBY REQUEST to be enrolled and authorize deductions, if any, from my wages for my share of the cost of the benefits for which I am eligible, or may be entitled, under the Group Policy or Policies issued.

DATE _____ SIGNATURE _____

COPY AS NEEDED