Excellus

DENTAL ENROLLMENT FORM

All Dates = mm/dd/yy ❑ **Check if name change** ❑ **Check if new address**

✓ **CHECK DESIRED ACTION**

❑ **Add** Subscriber (AA)
Date of Hire/Event ___/___/___
Coverage Eff Date ___/___/___

❑ **Add** Dependent (AB)
Date of Event ___/___/___
Coverage Eff Date ___/___/___

❑ **Change** Coverage (AC)
Coverage Eff Date ___/___/___

❑ **Cancel** Subscriber (S)
❑ **Cancel** Dependent (M)
❑ (D)ental
Cancellation Date /__/___

✓ **CHECK DESIRED COVERAGE**

❑ Dental Blue Options

✓ **CHECK PERSON(S) COVERED**
Self ☐
Family ☐

SUBSCRIBER INFORMATION - Must be completed ✓ Check if Married: ❑ Yes ❑ No Date of marriage: ___/___/___
Social Security # _____-_____-_____ Sex: ❑ M ❑ F Birthdate: ___/___/___
Last Name_____ First
Street_____
City_____ State_____ Zip
Day Phone: _____ E-mail Address: _____

FAMILY MEMBER INFORMATION ✓ **Check relationship and indicate dependent name or indicate dependent name and birthdate to be cancelled.**

Spouse ☐ Dependent ☐
Student ☐ Full time ☐ Part time ☐
Sex: M ☐ F ☐

Birthdate_____

SS#_____

Last Name_____

First Name_____

Spouse ☐ Dependent ☐
Student ☐ Full time ☐ Part time ☐
Sex: M ☐ F ☐

Birthdate_____

SS#_____

Last Name_____

First Name_____

Spouse ☐ Dependent ☐
Student ☐ Full time ☐ Part time ☐
Sex: M ☐ F ☐

Birthdate_____

SS#_____

Last Name_____

First Name_____

Subscriber Signature_____ Date_____