

**GROUP ENROLLMENT FORM**
**PLAN PACESETTER**

PLEASE PRINT

		FOR EMPLOYER USE ONLY	Group No.	Div. No.	Effective Date of Coverage	MM/DD/YY / /
Social Security No. - -	Last Name	First Name		Initial		
Street Address		City		State	Zip Code	Phone No. ( )
Date of Birth MM/DD/YY / /	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced/Separated <input type="checkbox"/> Widowed		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Full-Time Employment MM/DD/YY / /		
Name of Employer			Employer Address			

**Please complete the following for all family members  
enrolling in the dental plan.**

Last Name	First Name	MI	Sex	Date of Birth MM/DD/YY	Social Security #	Dentist #	Ortho #	Vision #
<b>SELF</b>	<b>DO NOT COMPLETE</b>							
Spouse			<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /	- -			
Dependent Child #1			<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /	- -			
Dependent Child #2			<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /	- -			
Dependent Child #3			<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /	- -			
Dependent Child #4			<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /	- -			
Dependent Child #5			<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /	- -			
Dependent Child #6			<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /	- -			
Dependent Child #7			<input type="checkbox"/> Male <input type="checkbox"/> Female	/ /	- -			

**AUTHORIZATION: Important. Please read and sign below if you are enrolling in the dental plan.**

- If I am required to contribute to the premium for any coverage elected on this form, I hereby authorize my employer to deduct such contributions in advance from wages due me, for remittance to Golden West Dental & Vision.
- I authorize my physician or medical professional, any hospital, clinic, any insurer or employer to give Golden West Dental & Vision or any consumer reporting agency acting on its behalf, information about me. Such information will pertain to my employment, other insurance coverage and medical care, advice, treatment or supplies for any physical or medical condition.

APPLICANT'S SIGNATURE \_\_\_\_\_

DATE SIGNED \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_