Plan Underwritten by: Dentcare®

Plan Administered by: healthplex

Dentcare Delivery Systems, Inc.
Attention: Enrollments Department
333 Earle Ovington Blvd., Suite 300
Uniondale, NY 11553-3608
P 1-877-591-1789 **F** 516-227-0582
yourdentalplan.com/healthplex

MANAGED CARE ENROLLMENT FORM

EMPLOYER INFORMATION

Employer's Name
CWA Local 1180 Actives & Retirees

Group Number	Effective Date
1730339 (64092)	

MEMBER INFORMATION

Last Name	First Name	M.I.	SSN: **XXX-XX-** **or** ID#:	
Address	City		State	Zip Code
Home Phone	Email Address		Gender	D.O.B.

Other Dental Coverage ☐Yes ☐No	Name of other plan (if applicable)

MARITAL STATUS

☐ Single ☐ Domestic Partners ☐ Married ☐ Divorced/Widow

SPOUSE/DOMESTIC PARTNER

Last Name, First Name	Gender	D.O.B.

DEPENDENTS TO BE COVERED - *Dependent Children are covered up to the end of the month of their 26th birthday.*

Last Name, First Name	Gender	D.O.B.
Last Name, First Name	Gender	D.O.B.
Last Name, First Name	Gender	D.O.B.
Last Name, First Name	Gender	D.O.B.
Last Name, First Name	Gender	D.O.B.

Dental Selection - *Please choose one Primary Care Dentist (PCD) from Dentcare Comprehensive Directory (one PCD per family).*

Dentist Name	Practitioner ID

By signing below, I affirm that I am employed by the above-referenced employer/group. I understand that my employer is responsible for the payment of monthly premium due to Dentcare Delivery Systems, Inc. for dental coverage.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Signature	Date