2022-2023

GROUP DENTAL ENROLLMENT FORM

TOTAL DENTAL ADMINISTRATORS, INC.

☐ New Employee	☐ Add Coverage	☐ Add/Delete Dependent	☐ Decline Coverage	☐ Cancel Coverage
☐ Address/Name Change	☐ Loss of Other Coverage	☐ Transfer From DHMO	☐ Transfer From PPO	☐ COBRA Enrollment

Name of School:	**District:** Alpine School District

Social Security Number	**Effective Date** Month / Day / Year	**Date Employed Fulltime** Month / Day / Year	**Hours Worked Per Week**

Peak Care Plus (formally DHMO)	**Elite Choice**	**TDA PPO/MAC**	**TDA Companion**
☐ Single **$13.75**	☐ Single **$28.44**	☐ Single **$36.15**	☐ Single **$39.92**
☐ Two-Party **$28.55**	☐ Two-Party **$59.24**	☐ Two-Party **$81.49**	☐ Two-Party **$85.80**
☐ Family **$44.77**	☐ Family **$97.81**	☐ Family **$137.56**	☐ Family **$141.49**
Dental Office Selected #			

Your Name (Last), (First), (MI)	**Date of Birth** Month / Day / Year	**Sex:** Male: ☐ Female: ☐

Home Address:	**Home Phone Number:**
	Work Phone Number:
	Email Address:
Do you have any other Dental coverage? If so, Carrier	

Complete for Dependent Coverage:			**Do any of your dependents have any other dental coverage?**	**If so, Name of Carrier:**
Spouse Name: (Last), (First), (MI)	**Sex:**	**Date of Birth:**		
		/ /	☐ Yes ☐ No	
CHILDREN 1.	/	/ /	☐ Yes ☐ No	
2.	/	/ /	☐ Yes ☐ No	
3.	/	/ /	☐ Yes ☐ No	
4.	/	/ /	☐ Yes ☐ No	
5.	/	/ /	☐ Yes ☐ No	
6.	/	/ /	☐ Yes ☐ No	

Fraud Warning (Not Applicable in AZ): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a 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 subjects such person to criminal and civil penalties.

I elect the dental coverage selected for which I am eligible. If any contribution from me is necessary to pay part of the cost of insurance. I authorize my employer to deduct the contribution from my wages.

Date **Employee Signature:**

Refusal of Group Dental Coverage: I have been offered this insurance coverage and decline to purchase it at this time. I understand that in the event I desire such insurance at a later date, I will be required to furnish evidence of insurability at my own expense, and the company will have the right to refuse any request.

Date **Employee Signature:**

For Personnel Use Only

Approved By: **Effective Date:**

2022-2023 Return To: **Alpine Education Association/Alpine UniServ 557 W. Center St., Pleasant Grove Ut 84062**

SCAN/E-MAIL TO annie@alpineuniserv.org **PHONE NUMBER 801-224-2055 ext 2**