



**MANAGED CARE ENROLLMENT FORM**

**EMPLOYER INFORMATION**

Employer's Name  
**Communication Workers of America - Local 1180 Security Benefits Fund**

Group Number **GG-043 (Actives)/GG-046 (Retirees)** Effective Date

**MEMBER INFORMATION**

Last Name First Name M.I. SSN: **XXX-XX- or ID#CWA-**

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.

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

Dentist Name Dentist Site Code

*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