



888.703.6999 www.libertydentalplan.com

Employer's Use Only	
Group #	Effective Date:
<input type="checkbox"/> COBRA Enrollment	COBRA End Date:

Application for Membership

<input type="checkbox"/> New Enrollment <input type="checkbox"/> Address Change <input type="checkbox"/> Add Dependent <input type="checkbox"/> Delete Dependent								
Name of Employer/Trust:								
Social Security Number:		Last Name:			First Name:			MI:
Birth Date:	Gender:		Street:		City:		State:	Zip Code:
	M	F						
	<input type="checkbox"/>	<input type="checkbox"/>						
Telephone:			Employee E-mail address:			Office Number:		
Preferred Written Language:			Preferred Spoken Language:			Ethnicity:		

List all Dependents to be Covered Under Your Plan

Last Name:	First Name:	MI:	Birth Date:	Gender:		Social Security Number:	Office Number:
				M	F		
Spouse/Domestic Partner:				<input type="checkbox"/>	<input type="checkbox"/>		
Child:				<input type="checkbox"/>	<input type="checkbox"/>		
Child:				<input type="checkbox"/>	<input type="checkbox"/>		
Child:				<input type="checkbox"/>	<input type="checkbox"/>		
Child:				<input type="checkbox"/>	<input type="checkbox"/>		
Child:				<input type="checkbox"/>	<input type="checkbox"/>		
Child:				<input type="checkbox"/>	<input type="checkbox"/>		
Child:				<input type="checkbox"/>	<input type="checkbox"/>		

I understand and agree that by enrolling with or accepting services from LIBERTY Dental Plan, I and any enrolled dependents are obligate to read, understand and abide by the terms, conditions and provisions of the Plan Contract or Insurance Policy. My signature below indicates that the information entered in this Application is complete, true and correct to the best of my knowledge and that I accept these terms.

Signature:	Date:
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DHMOSTANDARD20180423