



P.O. Box 8510 * St. Louis, MO 63126

New Enrollment/Change Form

Ph. (314) 543-4900 or (800) 501-3471

Fax (314) 849-4830 or (800) 501-8432

eligibility@essexdental.com

Group Name: _____			
Part I: Reason			
Birth of Child	Custody of Child	Loss of Other Coverage	Retired
COBRA	Death	Marriage	Termination
Coverage Type	Divorce	New Enrollment	Waive Coverage ¹
Other _____	Date of Change _____		
Part II: Provider Panel			Essex Dental Benefits
			Connection Dental

Part III: Employee Information							
1. Social Security No.	2. Last Name	First	MI	3. Birthdate	4. Gender		
5. Street Address	Apt. #	6. City	7. State	8. Zip Code			

Part IV: Dependent Information								
Add	Delete	First Name	MI	Last (if different)	Social Security No.	Birthdate	Gender	Relationship

Part V: Enrollment		Part VI: Coverage Type			Part VII: Product Type and Level (if applicable)		
1. Effective Date	2. Hire Date	Employee Only	Employee + 1	EPO	Option 1 (High)		
3. Group Name		Employee + Spouse	Family	Indemnity	Option 2 (Low)		
		Employee + Dependent(s)		PPO			

Part VIII: Other Benefit Information							
1. Do you have current orthodontic coverage?		Yes					
		No					
2. Are you or any of your dependents enrolled in another dental benefit program?			Yes	2a. Subscriber Name		2b. Social Security No.	
			No				
2c. Carrier Name		2d. Carrier Phone		2e. Carrier Address			
3. Are you or any of your dependents covered by another member under one of our benefit programs?			Yes	3a. Member's Name		3b. Social Security No.	
			No				

Part IX: Authorization

I have read the plan provisions provided by my employer and Essex Dental Benefits.

I authorize payment of dental benefits to the provider of my dental care and payroll deductions to cover my share, if any, of the dental premium.

I also authorize any dentist or provider of my dental care to release any information pertaining to my dental treatment to Essex Dental Benefits.

I certify that the above information is true and correct and authorize the processing of this form as indicated.

Employee Signature _____ Date _____ E-mail² _____

Employee: Please return this form to your Human Resources Department.
Human Resources Department: Please mail this form to Essex Dental Benefits, P.O. Box 8510, St. Louis, MO 63126-0510 or fax it to (314) 849-4830 or (800) 501-8432.

For Essex Dental Benefits Use Only			
Effective Date	Date Entered	Entered By	ID Card Requested

¹ Opt-out and late entrant limitations apply.
² For use by Essex Dental Benefits ONLY to communicate account and product updates.