DENTAL ENROLLMENT/CHANGE FORM

FAX Completed Form to: 888-273-6630

LOCAL: _____

A. **COVERAGE** (Select only those plans offered by your Local)

* Dental Coverage without Orthodontics

___ Member Only DENSF1 ___ Member + 1 DENSF2 ____Member + 2 or more DENSF3

* Dental Coverage with Orthodontics

____ Member Only DENSFO1 ___ Member + 1 DENSFO2 ___ Member + 2 or more DENSFO3

B. **EMPLOYEE INFORMATION**

New Enrollments: Date First Affiliated with CPF

First Name:	**Last Name:**	
Social Security No.:	**Date of Birth:**	**Gender: M / F**
Home Address:		
City:	**State: Zip:**	
Day / Cell Telephone No.	**Work Telephone No.**	

C. **CHANGES:**

___ Name Change ___ Add Dependent ___ Delete Dependent ___Address Change

Indicate effective date and reason for change:_____

Month Day Year Reason (i.e. Marriage/Divorce)

D. **DEPENDENT INFORMATION** (List those dependents being enrolled / deleted in the plan)

First Name	Last Name	Social Security #	Relationship	Date of Birth	Gender	Add/Delete

Signature_____ Date_____

file: CPFIT Dental 2005/CPF Insurance Trust Dental App