TDA
Total Dental Administrators

North Dakota

GROUP DENTAL ENROLLMENT FORM

☐ Annual Enrollment Period	☐ New Employee/Hire	☐ Decline Coverage	☐ Add or Delete Dependent (circle one)
☐ Address/Name Change	☐ Terminate Coverage	☐ COBRA Enrollment	☐ Qualifying Event:

Name of Employer (Use Name from Group Billing Notice or Master Application)	**Group Number**	**Division**	**Class**
MINOT STATE UNIVERSITY	**BTS NDE34978**		

TDA Plan Design: ☒ **Elite Choice**

Social Security Number	**Effective Date** Mo./Day/Year (4-digit)	**Date Employed Fulltime** Mo./Day/Year (4-digit)	**Hours Worked in Week**

Your Name: (Last), (First) (Middle Initial)	**Date of Birth** Mo./Day/Year (4-digit)	**Gender** ☐ Male ☐ Female
Home Address:		**Coverage Requested** ☐ Employee Only ☐ Employee + 1 Dependent ☐ Employee + 2 or More

Home Phone Number	**Work Phone Number**
Email Address	**Do you have *ANY* other Dental coverage?** ☐ Yes ☐ No If yes, carrier?

COMPLETE BELOW FOR DEPENDENT COVERAGE

	Spouse Name: (Last), (First) (Middle Initial)	**D.O.B.**	**Gender**	**Other Dental Coverage**	**Name of Carrier**
				Yes No	
C				Yes No	
H				Yes No	
I				Yes No	
L				Yes No	
D				Yes No	
R				Yes No	
E					
N					

FRAUD WARNING (Not Applicable in Arizona): 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.

Enrollment in Group Coverage: 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 hereby 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**

Total Dental Administrators, Inc. | 2800 North 44th Street, Suite 500, Phoenix, AZ 85008
Telephone (888) 422-1995 | Facsimile (602) 266-1948
www.TDAdental.com | eforms@TDAdental.com | customerservice@TDAdental.com

PLEASE RETURN TO: L. Ronne by mail, fax, or email: Lronne@TDAdental.com