

Application for Dental Plus Insurance

PLEASE TYPE OR PRINT



Add Accident Hospital Indemnity Plan: Yes No

Premium Amount: \$ _____ /

A. PERSONS TO BE INSURED

	Last	Name First	MI	Sex	Birthdate (MM/DD/YY)	Age
Proposed Insured						
Spouse						
Dependent Child						
Dependent Child						
Dependent Child						

Attach a separate sheet, signed and dated, if additional space is needed.

B. PERSONAL INFORMATION FOR PROPOSED INSURED

Residence Street Address _____ City _____ State _____ Zip _____

Day Time Phone Number _____ / _____ Cell Number _____ Best Time to Call _____ Email Address _____

Billing Address (if different than above)

Street _____ City _____ State _____ Zip _____ Phone Number _____

Occupation

Primary Insured - Employer Name _____

Spouse - Employer Name _____

Duties _____

Duties _____

C. OTHER COVERAGE IN FORCE

Is the Proposed Insured covered by, or has application been made for any type of dental insurance? Yes No

If "Yes", complete the section below.

Insurance Company Name	Policy Number	Phone Number (Include Area Code)	Effective Date (MM/DD/YY)

D. MEDICAL INFORMATION

	Primary		Spouse		Dependnt.	
	Yes	No	Yes	No	Yes	No
1. (a) Do you currently wear dentures?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) Have you been advised to have any dental work which has not been completed?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. (a) Do you currently wear eyeglasses or contact lenses?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) Have you received advice or treatment within the past nine months for correction of a vision problem?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. (a) Do you currently wear a hearing aid?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) Have you been treated for hearing loss within the past nine months?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) Has a physician recommended the purchase of a hearing aid to correct a hearing deficiency?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Provide details for any "Yes" answers for questions 1-3.

Primary: _____

Spouse: _____

Dependents: _____

