



**MANAGED CARE ENROLLMENT FORM**

**EMPLOYER INFORMATION**

Employer's Name <b>Communication Workers of America - Local 1180 Security Benefits Fund</b>	
Group Number <b>GG-043 (Actives)/GG-046 (Retirees)</b>	Effective Date

**MEMBER INFORMATION**

Last Name	First Name	M.I.	SSN: <b>XXX-XX- or ID#CWA-</b>	
Address		City	State	Zip Code
Home Phone	Email Address		Gender	D.O.B.
Other Dental Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of other plan (if applicable)			

**MARITAL STATUS**

Single
  Domestic Partners
  Married
  Divorced/Widow

**SPOUSE/DOMESTIC PARTNER**

Last Name, First Name	Gender	D.O.B.
-----------------------	--------	--------

**DEPENDENTS TO BE COVERED - *Dependent Children are covered up to the end of the month of their 26th birthday.***

Last Name, First Name	Gender	D.O.B.
Last Name, First Name	Gender	D.O.B.
Last Name, First Name	Gender	D.O.B.
Last Name, First Name	Gender	D.O.B.
Last Name, First Name	Gender	D.O.B.

**Dental Selection - *Please choose one Primary Care Dentist (PCD) from Dentcare Comprehensive Directory (one PCD per family).***

Dentist Name	Dentist Site Code
--------------	-------------------

*By signing below, I affirm that I am employed by the above-referenced employer/group. I understand that my employer is responsible for the payment of monthly premium due to Dentcare Delivery Systems, Inc. for dental coverage.*

**Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.**

Signature	Date
-----------	------