CWA LOCAL 1180
EMBLEM PREFERRED DENTAL ENROLLMENT FORM

I. SUBSCRIBER INFORMATION

Last Name	First Name	M.I.	Sex	Last 4 Digit SS #

Street Address	Apt.	City	State	Zip Code	Birth Date: MM/DD/YR

Coverage Type	Member Status	Marital Status:		
☐ Standard or ☐ Premium	☐ Active or ☐ Retiree	☐ Single ☐ Married ☐ Domestic Partner (DP)	Home Telephone #: _____ Work Telephone #: _____ Cell Telephone #: _____	Email Address: _____

II. ENROLLMENT INFORMATION – IF YOU ARE ENROLLING YOUR SPOUSE/DP AND/OR CHILDREN, PLEASE LIST BELOW

First Name Last Name	Last 4 Digit SS #	Sex	Relationship	Birth Date: MM/DD/YR	✓ If Disabled
Dependent			☐ Spouse ☐ DP ☐ Child		☐
Dependent			☐ Child		☐
Dependent			☐ Child		☐

YOUR SIGNATURE IS REQUIRED TO PROCESS THIS FORM.

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 MATERIAL FACT ASSOCIATED WITH SUCH APPLICATION COMMITS TO A FRAUDULENT INSURANCE ACT. SUCH ACT MAY BE SUBJECT TO COVERAGE TERMINATION.

APPLICANT MUST SIGN HERE: _____ **DATE:** _____

III. EMPLOYER INFORMATION – THIS SECTION TO BE COMPLETED BY EMPLOYER/CONTRACTOR GROUP

Name of Group: _____	Group Number: _____	Hire Date: _____ Waiting Period: _____	Date Submitted: _____

Requested Effective Date:	Dental:	Plan Name:	Approved By: (Group Plan Administrator)	Date Approved:
_____	_____	_____	_____	_____