Dental Application

HUMAN CAPITAL
A **Vensure Employer Services** Company

Section 1: Employee Information		
On-Site Employer:		
Subscriber Name (Last):	Subscriber Name (First):	(M.I.):
Street Address:		
City:	State:	ZIP Code:
Social Security Number:	Date of Birth:	Gender: ☐ Male ☐ Female
Marital Status: ☐ Single ☐ Married	Home Phone:	Work Phone:

Dependent Legal Name	Gender	Relation	Date of Birth	Social Security Number

Section 2: Coverage Election	Delta Dental Preferred PPO (Nationwide)	Delta Dental EPO (Michigan Only)
Employee	☐ $34.94	☐ $19.63 - Employee
Employee + Spouse	☐ $70.33	☐ $37.59 - Two Party
Employee + Child(ren)	☐ $79.35	☐ $75.76 - Family
Family	☐ $136.91	

Please Note: Rates Shown are ***Monthly.***

For more information, please call: 248.353.344.

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. By signing this I certify that the information on this form is correct.

Signature of Subscriber

Date

For Internal Use Only:				
☐ Carrier	☐ Prism	DOH:	Effective Date:	HR: