

**Come
To The
Harbor!**

- New Enrollment
 Change/Policy#: _____

Benefit Plan Enrollment/Change Form

Date: _____



Membership Options:	Plan Selection:
<input type="checkbox"/> Member Only	<input type="checkbox"/> Dental Only
<input type="checkbox"/> Member plus one dependant	<input type="checkbox"/> Dental, Vision, Rx, Chiropractic
<input type="checkbox"/> Member plus two or more dependents	Children only plan <input type="checkbox"/> Yes <input type="checkbox"/> No

General Information (must be completed)		
Last Name:	First Name:	MI:
Address 1:		
Address 2:		
City:	State:	Zip:
Home Phone:	Cell Phone:	Work Phone:
Social Security Number:	Birth Date:	E-Mail:

Dependent Coverage Information (complete only if enrolling)					
Name (last, first):	Birth Date:	Relationship:	Name (last, first):	Birth Date:	Relationship:
Name (last, first):	Birth Date:	Relationship:	Name (last, first):	Birth Date:	Relationship:
Name (last, first):	Birth Date:	Relationship:	Name (last, first):	Birth Date:	Relationship:
Name (last, first):	Birth Date:	Relationship:	Name (last, first):	Birth Date:	Relationship:

Signature Section	
Participating Dentists and other dental care providers are independent contractors and are neither agents nor employees of Harbor Dental Plan, LP. Harbor Dental Plan, LP does not provide dental care services and, therefore cannot guarantee any results or outcome of services. I hereby apply for the coverage(s) with Harbor Dental Plan, LP; I authorize the required payroll deduction for contributory benefits. I certify that all information provided in this application is accurate and complete.	
Member Signature:	Date ^(MM/DD/YYYY) :

Declination of Coverage	
I do not wish to enroll <input type="checkbox"/>	Signature: _____ Date: _____

Completed by Group Administrator	
Group/Company Name:	
Contact:	Telephone
Original Effective Date :	
Date change to be effective:	

For HDP Use Only	
Policy Number:	Effective Date:
Plan Change Date:	By: