TDA
Total Dental Administrators

North Dakota

GROUP DENTAL ENROLLMENT FORM

☐ Annual Enrollment Period	☐ New Employee/Hire	☐ Decline Coverage	☐ Add or ❑ Delete Dependent
☐ Address/Name Change	☐ Terminate Coverage	☐ COBRA Enrollment	☐ Qualifying Event:

Name of Employer (Use Name from Group Billing Notice or Master Application)	Group Number	Division	Class
NORTH DAKOTA STATE UNIVERSITY	BTV NDE44891		

TDA Plan Design: ☒ **Elite Choice**

Social Security Number	Effective Date Mo./Day/Year (4-digit)	Date Employed Fulltime Mo./Day/Year (4-digit)	Hours Worked in Week

Your Name: (Last), (First) (Middle Initial)	Date of Birth Mo./Day/Year (4-digit)	Gender ☐ Male ☐ Female

Home Address:	Coverage Requested ☐ Employee Only ☐ Employee + 1 Dependent ☐ Employee + 2 or More

Home Phone Number	Work Phone Number

Email Address	Do you have *ANY* other Dental coverage*?* ☐ Yes ☐ No If yes, carrier?

COMPLETE BELOW FOR DEPENDENT COVERAGE

	Spouse Name: (Last), (First) (Middle Initial)	D.O.B.	Gender	Other Dental Coverage	Name of Carrier
				❑ Yes ❑ No	
CHILDREN				❑ Yes ❑ No	
				❑ Yes ❑ No	
				❑ Yes ❑ No	
				❑ Yes ❑ No	
				❑ Yes ❑ No	
				❑ Yes ❑ No	

FRAUD WARNING (Not Applicable in Arizona): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a 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 subjects such person to criminal and civil penalties.

Enrollment in Group Coverage: I elect the dental coverage selected for which I am eligible. If any contribution from me is necessary to pay part of the cost of insurance, I hereby authorize my employer to deduct the contribution from my wages.

Date: **Employee Signature**

Refusal of Group Dental Coverage: I have been offered this insurance coverage and decline to purchase it at this time. I understand that in the event I desire such insurance at a later date, I will be required to furnish evidence of insurability at my own expense, and the company will have the right to refuse any request.

Date: **Employee Signature**

PLEASE RETURN TO: L. Ronne by mail, fax, or email: Lronne@TDAdental.com