# LIBERTY Dental Plan

888-401-1128
www.libertydentalplan.com

## APPLICATION FOR MEMBERSHIP

*Employer's Use Only*

*Group #* NV10122 *Effective Date:* _____

○ *COBRA Enrollment* *COBRA End Date:* _____

○ New Enrollment ○ Address Change ○ Add Dependent ○ Delete Dependent

| *Name of Employer/Trust* Personnel Plus, Inc | | | |
|---|---|---|---|
| Social Security Number | Last Name | First Name | MI |
| | | | |

| Birth Date | Gender M F | Street Address | City | State | Zip Code |
|---|---|---|---|---|---|
| | | | | | |

| Telephone ( ) | Language Preference |
|---|---|
| | |

| Employee E-mail Address | Provider ID Number |
|---|---|
| | N/A |

## LIST ALL DEPENDENTS TO BE COVERED UNDER YOUR PLAN

| | Last Name | First Name | MI | Birth Date | Gender | Social Security Number | Provider ID Number |
|---|---|---|---|---|---|---|---|
| Spouse/Domestic Partner | | | | | M F | | |
| Child | | | | | M F | | |
| Child | | | | | M F | | |
| Child | | | | | M F | | |
| Child | | | | | M F | | |
| Child | | | | | M F | | |
| Child | | | | | M F | | |
| Child | | | | | M F | | |

I understand and agree that by enrolling with or accepting services from LIBERTY Dental Plan, I and any enrolled dependents are obligated to read, understand and abide by the terms, conditions and provisions of the Plan Contract or Insurance Policy. My signature below indicates that the information entered in this Application is complete, true and correct to the best of my knowledge and that I accept these terms.

White: LIBERTY Dental Plan Copy Yellow: HR Copy Pink: Employee Copy

Employee Signature _____ Date