Newport Dental

# ENROLLMENT CARD

(PLEASE PRINT)

| Last Name | First Name | Initial | Social Security Number | |
|---|---|---|---|---|
| Street Address | City | State | Zip Code | Telephone |
| Employer/Organization | Sex M ☐ F ☐ | | Birthdate | |

List Below All Eligible Dependents That You Wish Covered

| Last Name (if different), First Name | Sex | Birthdate | Last Name (if different), First Name | Sex | Birthdate |
|---|---|---|---|---|---|
| | | | | | |
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FOR PLAN USE ONLY

Group #:

Effective Date:

I wish to enroll in the Newport Dental Plan. I understand that all necessary dental services will be charged as described in the Benefits Schedule and Co-Payments, and I and all my eligible dependents are subject to the limitations and exclusions of the Plan.

Applicant's Signature _____ Date _____

NDEF-GW

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