# Enrollment Application Form

## Application Information

Application Number:

Effective Date:

Total Premium:

## Primary Applicant

First Name: Last Name:

Date of Birth: Gender:

SSN:

## Mailing Address

Street:

City: State: Zip:

## Spouse (if applicable)

First Name: Last Name:

Date of Birth:

## Dependents

Dependent 1:

First: Last: DOB: Gender:

Dependent 2:

First: Last: DOB: Gender:

# ADDENDUM - ADDITIONAL COVERAGES

Group Number: N/A
Effective Date: N/A

| Applicant | Relationship | Coverage # | Type | Premium | Carrier |
|---|---|---|---|---|---|
| John Doe | PRIMARY | 2 | DENTAL | $60.0 | Cigna Dental |
| John Doe | PRIMARY | 3 | DENTAL | $55.0 | Guardian Dental |
| Jane Doe | SPOUSE | 2 | DENTAL | $55.0 | Cigna Dental |