LIBERTY DENTAL PLAN

888.703.6999 www.libertydentalplan.com

Employer's Use Only	
Group #	*Effective Date:*
☐ *COBRA Enrollment*	*COBRA End Date:*

Application for Membership

☐ New Enrollment ☐ Address Change ☐ Add Dependent ☐ Delete Dependent

Name of Employer/Trust:						
Social Security Number:	Last Name:	First Name:	MI:			
Birth Date:	Gender: M / F	Street:	City:	State:	Zip Code:	
Telephone:	Employee E-mail address:	Provider Office Number:				
Preferred Written Language:	Preferred Spoken Language:	Ethnicity:				

List all Dependents to be Covered Under Your Plan

Last Name:	First Name:	MI:	Birth Date:	Gender: M	Gender: F	Social Security Number:	Provider Office Number:
Spouse/Domestic Partner:							
Child:							
Child:							
Child:							
Child:							
Child:							
Child:							
Child:							

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.

Signature:	Date:

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