





3831

**Dependent Identification Number** (Social Security Number)      **Date of Birth** (mm/dd/yyyy)      **Gender**      **Provider Number** (DHMO only)

#3             /   /

**First Name**      **M.I.**      **Last Name**

**Dependent Identification Number** (Social Security Number)      **Date of Birth** (mm/dd/yyyy)      **Gender**      **Provider Number** (DHMO only)

#4             /   /

**First Name**      **M.I.**      **Last Name**

**Dependent Identification Number** (Social Security Number)      **Date of Birth** (mm/dd/yyyy)      **Gender**      **Provider Number** (DHMO only)

#5             /   /

**First Name**      **M.I.**      **Last Name**

**Dependent Identification Number** (Social Security Number)      **Date of Birth** (mm/dd/yyyy)      **Gender**      **Provider Number** (DHMO only)

#6             /   /

**First Name**      **M.I.**      **Last Name**

**SECTION E: OTHER DENTAL COVERAGE**—Do you or your dependent(s) have other Group Dental Coverage? Yes  No   
If your answer is yes, please complete the following information.

<b>Policyholder Name</b> (First, M.I., Last)	<b>Insurance Company</b>
<b>Policy/Identification Number</b>	<b>Effective Date</b> (mm/dd/yyyy) <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/>

I represent that all information supplied in this application is true and correct. Any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance 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.

Employee Signature      Phone Number      Email Address      Date

Employer Signature      Phone Number      Date

