

FITZHARRIS & COMPANY, INC.

814 FULTON STREET (RT 109) FARMINGDALE, NY 11735
PHONE: 1-800-635-5651 FAX: (516)777-5777 or 5778

Group/District Name: _____ **Account#** _____

Personnel/Human Resource Name: _____

<p style="text-align: center;">DENTAL</p> <p>Effective: ____/____/____</p> <p><input type="checkbox"/> SINGLE <input type="checkbox"/> FAMILY <input type="checkbox"/> EMPL/SPOUSE <input type="checkbox"/> EMPL/DEPENDENT</p>	<p>Hire Date: ____/____/____</p> <p>Occupation: _____</p> <p>Salary: \$ _____</p> <p>Phone #: (____) _____</p>
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SECTION 1 (Employee Information)

LAST NAME	FIRST NAME	MI	SEX <input type="checkbox"/> M <input type="checkbox"/> F	SOCIAL SECURITY NUMBER ____/____/____	EMPLOYEE DATE OF BIRTH MONTH DAY YEAR
STREET ADDRESS				MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> OTHER	
CITY		STATE		ZIP CODE	

SECTION 2 (Spouse Information)

NAME (LAST, FIRST, MI)	SEX <input type="checkbox"/> M <input type="checkbox"/> F	DATE OF BIRTH	SOCIAL SECURITY NUMBER
SPOUSE			
OTHER INSURANCE <input type="checkbox"/> Yes <input type="checkbox"/> No If yes are the dependents listed below also covered through that plan? <input type="checkbox"/> Yes <input type="checkbox"/> No			

SECTION 3 (Dependent Information)-If your dependent is handicapped-please include Dr.'s statement.

First (Last Name if different)	Sex	Birthday	Student	First (Last Name if different)	Sex	Birthday	Student
First: _____ Last: _____ SS# ____/____/____	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> YES <input type="checkbox"/> NO	First: _____ Last: _____ SS# ____/____/____	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> YES <input type="checkbox"/> NO
First: _____ Last: _____ SS# ____/____/____	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> YES <input type="checkbox"/> NO	First: _____ Last: _____ SS# ____/____/____	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> YES <input type="checkbox"/> NO
First: _____ Last: _____ SS# ____/____/____	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> YES <input type="checkbox"/> NO	First: _____ Last: _____ SS# ____/____/____	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> YES <input type="checkbox"/> NO

SECTION 4 (Change In Status)

<input type="checkbox"/> Change To Single Coverage Reason: _____	DATE OF CHANGE ____/____/____
<input type="checkbox"/> Change To Family Coverage	DATE OF CHANGE ____/____/____
<input type="checkbox"/> Name Change Married Name _____ Maiden Name _____	DATE OF CHANGE ____/____/____
<input type="checkbox"/> Cancellation I VOLUNTARILY CANCEL MY INSURANCE FOR MYSELF AND/OR DEPENDENTS	DATE OF CHANGE ____/____/____
<input type="checkbox"/> Cobra Employee Reason: _____ (Eligible to continue for 18 months)	DATE OF CHANGE ____/____/____
<input type="checkbox"/> Cobra Dependent Reason: _____ (Eligible to continue for 36 months)	DATE OF CHANGE ____/____/____
<input type="checkbox"/> Survivor Coverage (See guidelines and limitations in your benefit booklet)	DATE OF CHANGE ____/____/____
<input type="checkbox"/> Retiree Coverage Type of Coverage: <input type="checkbox"/> Single <input type="checkbox"/> Family OTHER _____	DATE OF CHANGE ____/____/____
<input type="checkbox"/> Addition/Termination of Dependent(s) Reason: _____	DATE OF CHANGE ____/____/____

- Request to participate – I hereby request to participate in the insurance program and agree to contribute in the appropriate manner, if required.
- Waiver of Insurance – I do not wish to participate in the insurance program offered through my employer, and I understand that if I desire to participate in the plan at a later date, my benefits may be denied or reduced. **(BENEFITS CONTRACTED ON A NON-CONTRIBUTORY BASIS CANNOT BE REFUSED.)**

" Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent act, which is a crime, and shall be subjected to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation."

The information provided above is true and correct to the best of my knowledge.

Employee Signature: _____

Date: ____/____/____