60 East South Temple • P.O. Box 45530
Salt Lake City, Utah 84145
Telephone 1-801-578-5600 • Toll Free 1-800-777-3622
Fax Number 1-801-578-5933
Web Site: www.dmba.com

COMPANY CODE	EFFECTIVE DATE
A03	

COBRA (MEDICAL/DENTAL) INSURANCE APPLICATION

❑ New Enrollment ❑ Change / Other (Please specify):____________________________

A. APPLICANT INFORMATION: Complete in full and return to Deseret Mutual. Report any changes immediately.

NAME: ____
FIRST MIDDLE INITIAL LAST

SOC. SEC. NO.: ______________________ BIRTH DATE: ______________________
MONTH DAY YEAR

FORMER DESERET MUTUAL ID NO.: ______________________________________

HOME ADDRESS: ____

CITY: ______________________ STATE: __________ ZIP CODE: ______________

HOME TELEPHONE: (______) ______________________ WORK TELEPHONE: (______) ______________________

SEX: ❑ MALE ❑ FEMALE MARITAL STATUS: ❑ MARRIED ❑ WIDOWED ❑ SINGLE ❑ DIVORCED

B. APPLICATION FOR INSURANCE BENEFITS

I WOULD LIKE MY LEVEL OF INSURANCE COVERAGE TO BE (Choose one):

❑ FOR MYSELF ❑ FOR MYSELF AND ONE DEPENDENT ❑ FOR MYSELF AND TWO OR MORE DEPENDENTS

CHOOSE ONE OF THE FOLLOWING:

❑ DESERET CHOICE + DENTAL (For Deseret Choice Hawaii, list PCP name and number below)

❑ DESERET SELECT + DENTAL

❑ DESERET PREMIER + DENTAL

❑ DESERET VALUE + DENTAL

❑ HMO + DENTAL (SPECIFY HMO NAME: ________________________________) *You must also submit the HMO application*

❑ DENTAL ONLY

NAME OF DEPENDENT (FIRST, MIDDLE INITIAL, LAST)	BIRTH DATE (MO, DAY, YR)	RELATIONSHIP TO PARTICIPANT	SEX	FOR DESERET CHOICE HAWAII ONLY PCP NAME & NUMBER
APPLICANT:		SELF		
SPOUSE:				

If any of your dependents are covered by another medical or dental insurance plan, please list the dependent and the name, address, and policy number of the other insurance carrier.

NAME OF DEPENDENT (FIRST, MIDDLE INITIAL, LAST)	NAME OF OTHER INSURANCE	ADDRESS (STREET, CITY, STATE, ZIP CODE)	POLICY NUMBER

C. PARTICIPANT AUTHORIZATION (REQUIRED)

❑ I WISH TO ENROLL OR MAKE CHANGES AS INDICATED ON THIS FORM.

❑ I WISH TO DISCONTINUE BENEFITS.

Signature: ______________________________________ Date: ______________________