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FOR DESERET MUTUAL USE ONLY	
RETIREMENT DATE OR EFFECTIVE DATE OF CHANGE	COMPANY CODE

SENIOR DENTAL PLAN ENROLLMENT FORM

New retiree Change _____

A. PERSONAL INFORMATION

Retiree name: _____ Deseret Mutual ID number: _____
 Home address: _____ Phone number: (____) _____
 City: _____ State: _____ ZIP code: _____
 Birth date: _____ Marital status: _____

B. SELECTED DENTAL COVERAGE

- I want to enroll in the Senior Dental Plan. (Complete parts D and F of this form. If you don't have medical coverage with Deseret Mutual, also complete part C.)
- I do not want to enroll in the Senior Dental Plan. (Complete part E.)

C. LEVEL OF COVERAGE and DEPENDENT INFORMATION

If you have medical coverage with Deseret Mutual, you don't need to complete this part. Your level of dental coverage will be the same as your level of medical coverage.

If you're enrolling in the Senior Dental Plan only, complete this part. Select your level of insurance coverage.

- For myself
- For myself and one dependent
- For myself and two or more dependents

List your spouse and all legal dependents from oldest to youngest. **If you omit any dependent or fail to add new dependents, that person(s) will *not* be covered.**

DEPENDENT NAME (FIRST, MIDDLE, LAST)	BIRTH DATE (MM/DD/YYYY)	RELATIONSHIP TO RETIREE	SEX	SOCIAL SECURITY NUMBER
		Spouse		

D. RETIREE AUTHORIZATION

I hereby apply for the insurance benefits specified. I understand the benefits of this plan, including the various options and conditions given above. Furthermore, I authorize any dentist, clinic, any other provider of dental care, insurance company, or my former employer to disclose to Deseret Mutual or its representatives all information and records about any condition or treatment of me, my spouse, or my dependents relating to diagnosis, treatment, history, and condition.

I further understand that if I choose to enroll in the Senior Dental Plan, I must remain enrolled in the plan for at least two years and will pay the required premium for such coverage. I authorize the deduction of premiums from my Master Retirement Plan check. If my Master Retirement Plan check is not large enough to cover the premium, I understand I will be billed individually for this coverage and agree to pay the premium to Deseret Mutual.

Printed name: _____ DMID: _____

Retiree signature: _____ Date: _____

E. RETIREE WAIVER OF INSURANCE BENEFITS (SIGN ONLY IF YOU REJECT BENEFITS.)

I understand the benefits of the Senior Dental Plan. I choose *not* to participate in this plan for myself and/or my dependents and hereby waive such coverage. **I also understand that in waiving this coverage, I am *not* eligible to enroll at a later date.**

Printed name: _____ DMID: _____

Retiree signature: _____ Date: _____

F. OTHER DENTAL INSURANCE

Are you covered by any other dental plan? Yes No

If yes, provide the following information:

Carrier name: _____

Carrier address: _____

Carrier telephone number: (_____) _____

Policy holder: _____

Policy number: _____

G. DESERET MUTUAL USE ONLY

Employment Status	Underwriting Status	Benefit Package	Contract Type	Risk Population	Premium Split Code	Bill to Code	Comments: _____	Date: _____
							Monthly Dental Premium: _____	