DMBA
150 Social Hall Avenue, Suite 170
P.O. Box 45530 • Salt Lake City, UT 84145
Telephone: 801-578-5600 • Toll free: 800-777-3622
Fax: 801-578-5933 • Website: www.dmba.com

COBRA MEDICAL & DENTAL ENROLLMENT FORM

❑ **NEW ENROLLMENT** ❑ **MID-YEAR CHANGE** ❑ **OPEN ENROLLMENT**

A. PARTICIPANT INFORMATION (Complete in full and return to DMBA. Report changes immediately.)

Name: _____

Former DMBA ID number: _____

Social Security number: _____ Birth date (mm/dd/yyyy): _____

Home address: _____

City: _____ State: _____ ZIP code: _____

Home telephone: _____ Work telephone: _____

Sex: ❑ Male ❑ Female Marital status: ❑ Married ❑ Widowed ❑ Single ❑ Divorced

B. CHOOSING YOUR BENEFITS

CHOOSE WHO TO ENROLL:

❑ Myself ❑ Myself and one dependent ❑ Myself and two or more dependents

CHOOSE YOUR MEDICAL PLAN (*plan availability based on location):

❑ Deseret Premier ❑ Deseret Select* ❑ Deseret Choice Hawaii*

❑ Deseret Value ❑ Deseret Protect ❑ Kaiser* (If you choose Kaiser, please complete the appropriate Kaiser application for where you live.)

❑ Waiving medical

CHOOSE YOUR DENTAL PLAN:

❑ Deseret Dental ❑ Deseret Dental *PLUS* ❑ Waiving dental

CHOOSE YOUR VISION PLAN:

❑ VSP ***with*** an annual eye exam ❑ VSP ***without*** an annual eye exam ❑ Waiving vision

C. PARTICIPANT AUTHORIZATION (REQUIRED)

❑ I wish to enroll or make changes as indicated on this form.

❑ I wish to discontinue COBRA enrollment.

My signature acknowledges that I have read and agree to the terms and conditions of the coverage applied for herein.

Signature: _____ Date: _____

PLEASE SEE THE BACK OF THIS FORM

D. DEPENDENT INFORMATION

RELATIONSHIP TO PARTICIPANT		DEPENDENT NAME (FIRST, MIDDLE INITIAL, LAST)	BIRTH DATE (MM/DD/YYYY)	SEX	SOCIAL SECURITY NUMBER
S - Legal Spouse N - Natural or Adopted Child SC - Step-child MC - Married Child GC - Grand-child O - Other				M F	
				M F	
				M F	
				M F	
				M F	
				M F	
				M F	

E. OTHER MEDICAL OR DENTAL COVERAGE

If you or any dependents are covered by any other medical or dental plan(s), please complete the following information or attach a copy of your health insurance card(s). If you no longer have your insurance cards, please contact your other insurance carrier and request a letter verifying your coverage and send it to DMBA.

Other insurance carrier name:_____ Phone number:_____

Policy holder:_____ ID number: _____