

Liberty Dental Plan of California

3636 Birch, Ste. 250 Newport Beach, CA 92660

Phone 888-703-6999 • Fax 949-223-0011

APPLICATION FOR MEMBERSHIP

Provider Choice #1: _____	Provider Choice #2: _____
------------------------------	------------------------------

Last Name	First Name	Initial	Social Security Number	Male <input type="checkbox"/>
				Female <input type="checkbox"/>
Street Address	City	State	Zip Code	Home Telephone
				Birth Date

LIST ALL ADDITIONAL DEPENDENTS BELOW: (Spouse and unmarried children to age 23 (full time student))

Last Name	First	Sex	Birth date
Spouse			
Child			
Child			
Child			
Child			
Child			
Child			
Child			

Northwestern Plan Administrators

Administrator

Effective Date

Plan (check one)

New Membership

CA40

Family Addition

CA90

I understand that the benefits, for which we will be eligible, will be in accordance with the Master Contract which is applicable to the type of and length of coverage under which I am enrolled and on file with my Group and Employer. I understand that it is my responsibility to report to Liberty Dental Plan any change in the eligibility of my dependents, that the benefits of this plan are coordinated with any other dental benefit of service plan and that any differences between any member and Liberty Dental Plan in tort or contract are subject to binding arbitration. I hereby authorize Liberty Dental Plan to release all medical records.

Signature of Employee

Date