PacificDental Benefits, Inc
ENROLLMENT APPLICATION

FOR ADMINISTRATIVE USE ONLY	
Grp #	Effective Date

Social Security Number: | | | | | | | | | | | |

Name: Last	First	MI
Address		
City	State	Zip Code
Home phone	Work phone	
Indicate Selected Name of Dentist		Dentist #

Choose coverage level: ☐ Employee Only ☐ Employee plus one ☐ Employee plus Family

Covered Individual Information:

Relation to Employee	Last Name	First Name	Social Security #	Date of Birth
Employee				
Spouse				
Child				
Child				
Child				
Child				

Signature of Enrollee

Date