



**LIBERTY Dental Plan**

888-703-6999

www.libertydentalplan.com

**APPLICATION FOR MEMBERSHIP**

*Employer's Use Only*

Group # \_\_\_\_\_ Effective Date: \_\_\_\_\_

COBRA Enrollment COBRA End Date: \_\_\_\_\_

Last Name		First Name		MI	Social Security Number		Birth Date	
Street Address			City	State	Zip Code	Telephone (    )		Sex

**LIST ALL DEPENDENTS TO BE COVERED UNDER YOUR PLAN**

Last Name	First Name	Sex	Birth Date
Spouse/ Domestic Partner			
Child			
Child			
Child			
Child			
Child			
Child			

\_\_\_\_\_  
*Name of Employer/Trust*

\_\_\_\_\_  
*Provider ID Number*

\_\_\_\_\_  
*Language Preference*

New Enrollment

Add Dependent

Address Change

Delete Dependent

\_\_\_\_\_  
*Employee E-mail Address*

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

White: LIBERTY Dental Plan Copy

Yellow: HR Copy

Pink: Employee Copy