



BEST HEALTH PLANS

PO Box 19721 Irvine, CA 92623-9721 877-247-6778
Offered by National Pacific Dental, Inc.

Your primary language, if not English: _____

Please check any special requirements:

- Interpreter Large Print Audio Tape
- Braille TDYY Other _____

DENTAL PLAN ENROLLMENT FORM

Employer: _____ Work Ph.: _____ Home Ph.: _____

Name: _____

Last
First
MI
Social Security Number

Home Address: _____ City: _____ State: _____ Zip: _____

Marital Status: Single Married Widowed Divorced

Please enroll me in the Dental Plan. I agree for myself and my dependents:

1. To be bound by the benefits, exclusions, limitations, fee schedules, and other terms of the group agreement and as the group agreement is amended.
2. That all dental care services must be obtained from the provider listed unless the Dental Plan specifically provides otherwise.
3. That all the information supplied herein is true and complete to the best of my knowledge.

I authorize deductions from my wages for the following dental coverage:

- Employee Only Employee plus Spouse
- Employee plus Child(ren) Employee plus Family

PLAN EFFECTIVE DATE: ____/____/____

LAST	FIRST	MI	M/F	DATE OF BIRTH	DENTISTS' NAME & ID NUMBER
SELF					
SPOUSE					
CHILD					
CHILD					
CHILD					
CHILD					
CHILD					
EMPLOYEE SIGNATURE		DATE SIGNED		WHITE – NPD YELLOW – Employer PINK - Employee	