



Please complete the information below if your employer is offering Dental coverage with your Rocky Mountain Health Plans medical coverage.

Name of Employer Group:			
Employee Information			
Last Name:		First Name:	
Date of Birth: / /	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number:	
Home Address:		City, State:	Zipcode:
<input type="checkbox"/> Yes, I am enrolling in Dental coverage, in addition to the medical plan. <input type="checkbox"/> Yes, I am enrolling in Dental coverage and waiving enrollment in the medical plan. Coverage requested for: <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + Spouse <input type="checkbox"/> Employee + Child(ren) <input type="checkbox"/> Employee + Family <input type="checkbox"/> I have listed dependents enrolling in the Dental Plan below.			
<input type="checkbox"/> I am waiving dental coverage. I understand I am also waiving dental coverage for any eligible dependents and my next opportunity to enroll in the dental plan will be Open Enrollment.			
Dependent Name	Gender	Birthdate	Relationship to Employee
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Signature:	Date:
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