DMS DENTAL PLAN ENROLLMENT FORM
For
Town of Marshfield

Effective Date: _____ **Date of Hire:** ___/___/___ **Date of Birth** ___/___/___

Last Name: _____ **First:** _____ **Initial:** ___

Street: _____ **City:** _____

State: _____ **Zip Code:** _____ **Home Phone** (_____) _____ **Sex M / F**

Social Security #_____ **Marital Status:** _____

I apply for coverage on:

____**myself only** ____ **myself +one dependents (spouse/child)** _____ **myself and eligible dependents**

Last Name (if different)	Sex M or F	Date of Birth	Last Name (if different)	Sex M or F	Date of Birth
2. Spouse			5.		
3. Child			6.		
4.			7.		

Please check option

____ DMS Dental (Network Option) Dental Office Selected: _____

(All dependents are assigned to the same office)

I hereby authorize payroll deductions from my earnings for any contribution required. This authorization remains in effect until revoked by me in writing.

Patient Privacy Statement

In accordance with recent Federal and State Laws regarding privacy or patient's records and information, please be advised that we will not disclose your personal health information (PHI) to anyone with out your authorization or as otherwise permitted or required by law.

Employee Signature: _____ **Date:** ___/___/___

I agree to stay on the dental program for a minimum of one year (the exception being termination of employment)

Please call DMS Dental at 800-456-8715 with any questions.