

Dental Health Services

3833 Atlantic Avenue, Long Beach, CA 90807 Tel. 562.595.6000

UTU Enrollment Form

Member Information

Last Name			First Name			M.I.			
Social Security #		Date of Birth		Participating Dentist Number		Sex <input type="checkbox"/> Female <input type="checkbox"/> Male			
Address			City		State	Zip	Phone ()		

Company Information

Company Name <i>United Transportation Union</i>			Date of Hire			Badge #		
Address <i>15999 Cypress Avenue</i>			City <i>Irwindale</i>		State <i>CA</i>		Zip <i>91706</i>	

Enrollment Information

Full Time Part Time COBRA

I request coverage for the following:

Dependant Information

Last Name	First Name	M.I.	Sex		Date of Birth (mo-day-yr)	Relationship	Participating Dentist Number
			F	M			

I hereby request coverage and authorize payroll deductions (if applicable) from my earnings for any contributions required for a minimum of one year. Authorization is granted to release my patient history to Dental Health Services, consulting health professional or other entity designated or approved by Dental Health Services for the purpose of certifying, purchasing, providing, evaluating, or administering benefits. This authorization remains in effect until revoked by me in writing.

Member Signature

Date

TRUST FUND USE ONLY

<u>Effective Date of Enrollment</u>	<u>Group #</u>	<u>Department #</u>
<u>Authorized by</u>	<u>Date</u>	

