FITZHARRIS & COMPANY, INC.
PO BOX 9182 FARMINGDALE, NY 11735
PHONE: 1-800-635-5651 FAX: (516)777-5777 or 5778

Group/District Name: ______________________ **Account#** ____________

Personnel/Human Resource Name: ______________________

DENTAL		
Effective: ____/____/____		Hire Date: ____/____/____
☐ SINGLE		Occupation: ____________
☐ FAMILY		Salary: $____________
☐ EMPL/SPOUSE		Phone #: (____)________
☐ EMPL/DEPENDENT		

SECTION 1 (Employee Information)

LAST NAME	FIRST NAME	MI	SEX	SOCIAL SECURITY NUMBER	EMPLOYEE DATE OF BIRTH
			M☐ F☐	/ /	MONTH DAY YEAR
STREET ADDRESS				MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ OTHER________	
CITY	STATE			ZIP CODE	

SECTION 2 (Spouse Information)

NAME (LAST, FIRST, MI)	SEX	DATE OF BIRTH	SOCIAL SECURITY NUMBER
SPOUSE	☐M ☐F		

OTHER INSURANCE ☐ Yes ☐ No If yes are the dependents listed below also covered through that plan? ☐ Yes ☐ No

SECTION 3 (Dependent Information)-If your dependent is handicapped-please include Dr.'s statement.

First (Last Name if different)	Sex	Birthday	Student	First (Last Name if different)	Sex	Birthday	Student
First: ________ Last: ________ SS# ____/____/____	☐M ☐F		☐ YES ☐ NO	First: ________ Last: ________ SS# ____/____/____	☐M ☐F		☐ YES ☐ NO
First: ________ Last: ________ SS# ____/____/____	☐M ☐F		☐ YES ☐ NO	First: ________ Last: ________ SS# ____/____/____	☐M ☐F		☐ YES ☐ NO
First: ________ Last: ________ SS# ____/____/____	☐M ☐F		☐ YES ☐ NO	First: ________ Last: ________ SS# ____/____/____	☐M ☐F		☐ YES ☐ NO

SECTION 4 (Change In Status)

	DATE OF CHANGE
☐Change To Single Coverage Reason:________ ☐Change To Family Coverage	___/___/_____
☐Name Change Married Name________ Maiden Name________	___/___/_____
☐Cancellation I VOLUNTARILY CANCEL MY INSURANCE FOR MYSELF AND/OR DEPENDENTS	___/___/_____
☐Cobra Employee (Eligible to continue for 18 months) Reason:________	___/___/_____
☐Cobra Dependent (Eligible to continue for 36 months) Reason:________	___/___/_____
☐Survivor Coverage (See guidelines and limitations in your benefit booklet)	___/___/_____
☐Retiree Coverage Type of Coverage: ☐ Single ☐ Family OTHER________	___/___/_____
☐Addition/Termination of Dependent(s) Reason:________	___/___/_____

☐ Request to participate – I hereby request to participate in the insurance program and agree to contribute in the appropriate manner, if required.

☐ Waiver of Insurance – I do not wish to participate in the insurance program offered through my employer, and I understand that if I desire to participate in the plan at a later date, my benefits may be denied or reduced. (**BENEFITS CONTRACTED ON A NON-CONTRIBUTORY BASIS CANNOT BE REFUSED.)**

" Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent act, which is a crime, and shall be subjected to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation."

The information provided above is true and correct to the best of my knowledge.

Employee Signature: ______________________ **Date:** ____/____/______