

Dental Enrollment Form

Employer: _____

Employee Name: _____

Employee Address: _____

City, State & Zip: _____

Social Security Number: _____

Work Phone with extension: _____

Date of Birth: _____ Male _____ Female _____

Date of Hire: _____

Date coverage begins: _____

Dependent Information (if covered):

| Name | Relationship | DOB | SSN# |
|------|--------------|-----|------|
|------|--------------|-----|------|

| Name | Relationship | DOB | SSN# |
|------|--------------|-----|------|
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| Name | Relationship | DOB | SSN# |
|------|--------------|-----|------|
|------|--------------|-----|------|

| Name | Relationship | DOB | SSN# |
|------|--------------|-----|------|
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