

# CARA Ameritas Dental Employee Application

New Enrollment     
  Add Dependent(s)     
  Address Change     
 Effective Date :

## Employer Group Information

Group Name :

Group # or Client # :

## Employee Information

SS # :                                      Date of Birth :                                      Sex :  Male     Female

Last Name :                                      First Name :                                      M. I. :

Address :

City :                                      State :                                      Zip Code :

Marital Status :  Single     Married     Divorced     Widowed

**Select Coverage :**     Employee Only     Employee + 1     Employee + 2 or More

<input type="checkbox"/> Spouse	Last Name :	First Name :
<input type="checkbox"/> Domestic Partner	Sex : <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth :

Child # 1	Last Name :	First Name :
	Sex : <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth :

Child # 2	Last Name :	First Name :
	Sex : <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth :

Child # 3	Last Name :	First Name :
	Sex : <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth :

Child # 4	Last Name :	First Name :
	Sex : <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth :

Check here  if additional sheet(s) is attached with this application

**X**

**Applicant Signature**

**Date**

Distributed By :

Administered By :

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 Fax : 510.893.4445  
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