

**Dental Enrollment Form**  
**Lake County Board of County Commissioners**

- New Enrollment (does not currently have dental coverage/has never had coverage)  
 Change  
 Drop my coverage

Please complete the following information:							
Social Security No.		Last Name		First		MI	Date of Birth / /
Home Address				Home Phone ( )		Sex M <input type="checkbox"/> F <input type="checkbox"/>	
City		State	ZIP Code		Business Phone ( )		Dental Facility # (for DHMO only)
List All Your Eligible Dependents That Are To Be Covered							
Add	Drop	First	MI	Last	Facility Number (for DHMO only)	Sex	Birth Date
<input type="checkbox"/>	<input type="checkbox"/>	Spouse:				M <input type="checkbox"/> F <input type="checkbox"/>	/ /
<input type="checkbox"/>	<input type="checkbox"/>	Child:				M <input type="checkbox"/> F <input type="checkbox"/>	/ /
<input type="checkbox"/>	<input type="checkbox"/>	Child:				M <input type="checkbox"/> F <input type="checkbox"/>	/ /
<input type="checkbox"/>	<input type="checkbox"/>	Child:				M <input type="checkbox"/> F <input type="checkbox"/>	/ /
<input type="checkbox"/>	<input type="checkbox"/>	Child:				M <input type="checkbox"/> F <input type="checkbox"/>	/ /
<input type="checkbox"/>	<input type="checkbox"/>	Child:				M <input type="checkbox"/> F <input type="checkbox"/>	/ /
<input type="checkbox"/>	<input type="checkbox"/>	Child:				M <input type="checkbox"/> F <input type="checkbox"/>	/ /
# Dependents Covered		Plan Code	Group Number <b>6045</b>		Division		Effective Date

PLEASE CHECK YOUR CHOICE ✓		
<input type="checkbox"/> <b>DHMO</b> (CP6045/CS150)	<input type="checkbox"/> <b>PPO</b> (CD6045/Elite Preferred)	<input type="checkbox"/> <b>Advantage</b> (CF6045/AVN2)

I wish to enroll in the plan indicated above as offered through my employer. I hereby authorize my employer to deduct all applicable contribution amounts from my salary or other compensation for the plan year, and for future renewal period(s). I understand that such contribution rate is subject to change on the anniversary date of the plan. I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_