45 E. Milwaukee St. | Detroit, MI 48202 | f: (844) 919-1601 | dencap.com

DENCAP Dental Plans Request Form - New ENROLLMENT

Clear Data

- Complete the "Employee Section" of this form including employee signature, then return to your group administrator.
- This form is NOT for making changes to existing subscribers. Please use the Change/Delete form if making changes to an already enrolled employee.
- For participating network dental locations, visit dencap.com
- Your Member I.D. Card will be mailed within 2 weeks of receipt of form.
- Contact your group administrator to make changes to your coverage.

TODAY'S DATE: ____/____/ 20____

EMPLOYEE SECTION: *Required information, this section MUST be completed*

LAST NAME (Print)	FIRST	INITIAL	DATE OF BIRTH MONTH DAY YEAR	SEX	SOCIAL SECURITY NUMBER
STREET ADDRESS		Apt#		☐ M ☐ F	– –
CITY	STATE	ZIP	PHONE NUMBER: -		
For DHMO Only Dental Office Selection *(Enter 4 digit number from Provider Directory)* ➡ ☐☐☐☐			E-MAIL:		

LIST ALL DEPENDENTS TO BE COVERED BELOW. INCLUDE LAST NAME IF DIFFERENT FROM SUBSCRIBER		DATE OF BIRTH MONTH DAY YEAR	Qualified Disabled Dependent	SEX	SOCIAL SECURITY NUMBER
SPOUSE				☐ M ☐ F	– –
DEPENDENT			YES ☐	☐ M ☐ F	– –
DEPENDENT			YES ☐	☐ M ☐ F	– –
DEPENDENT			YES ☐	☐ M ☐ F	– –
DEPENDENT			YES ☐	☐ M ☐ F	– –

➡ **EMPLOYEE SIGNATURE:**_____ **DATE:** _____

GROUP ADMINISTRATOR SECTION: *Required information, this section MUST be completed*

COMPANY NAME *OR* GROUP NUMBER: _____

PLAN SELECTION:_____

DESIRED EFFECTIVE DATE:

Please START coverage on the FIRST DAY of MONTH: _____ **YEAR:**_____

To ensure that your addition will be effective for the current month, please submit by the 10th of the current month. In some cases, enrollments can be processed for the current month when received later than the 10th of the month, but are not guaranteed. If an invalid date or no date is entered in the desired effective date field, the earliest date possible will be used.

ADMINISTRATOR SIGNATURE:_____ **TITLE:** _____ **DATE:** _____
REQUIRED

Group Administrator: Please retain a copy of completed form for your records

- If submitting electronically, type your name in the administrator signature box.
(Your e-mail to DENCAP serves as a binding signature.)

Email This Form

f5:V.04.18.23

Return this form to: DENCAP Dental Plans, Inc., 45 E. Milwaukee St., Detroit, MI 48202. Or fax to 844-919-1601. Or email to enrollments@dencap.com