Redwood Health Services

Enrollment Application for Dental / Vision Coverage

Return this form to your employer, not to RHS.

Employee Information

Social Security Number:	Date of Birth:	Date of Hire:	Gender	Coverage
			☐ M ☐ F	☐ Dental ☐ Vision

Last Name	First Name	MI

Home Address:

City: | State: | Zip Code:

Home Phone: | Work Phone:

Mailing Address (if different from home):

Employer Use Only

☐ Add ☐ Termination ☐ Other

Group Number	Effective Date			Employer (Name of Company)
	MONTH	DAY	YEAR	

Employment Status	Date of Hire				COBRA Effective Date:		
☐ Actively Employed ☐ Retired	MONTH	DAY	YEAR	☐ Initial Enrollment ☐ COBRA Continuation ☐ 18 months ☐ 36 months	MONTH	DAY	YEAR

List below: All dependents covered by this enrollment. Only your spouse and eligible unmarried dependents may be included.

Social Security Number:	Last Name:	First Name:	MI	Relationship	Date of Birth	Gender	FT Student
						☐ M ☐ F	☐ Y ☐ N
						☐ M ☐ F	☐ Y ☐ N
						☐ M ☐ F	☐ Y ☐ N
						☐ M ☐ F	☐ Y ☐ N
						☐ M ☐ F	☐ Y ☐ N
						☐ M ☐ F	☐ Y ☐ N

If eligible family members are covered by other dental or vision insurance, please so indicate.

Are you or any of your dependents currently covered by another dental or vision plan? ☐ Yes ☐ No

If yes, name of the employee covered on the other policy:

Name(s) of the family member(s) covered on the other policy:

Name of the insurance company: | Name of the employer:

Effective date: | SS# of the policyholder:

I represent that the above information is true and I hereby authorize payroll deductions from my earnings for any contributions or fees as may be required to maintain my eligibility.

Signature: _____ **Date:** _____