Administered by:

healthplex

Return Completed Form to:
Detectives' Endowment Association
26 Thomas Street
New York, NY 10007
P 212-587-9120 **F** 212-587-9149

Dental Plan Enrollment Form

Employer Information				
Employer's Name				
Group Number	Effective Date			
Member Information				
Last Name	First Name	M.I.	SSN/ID #	
Address	City	State	Zip Code	
Home Phone	Email Address	Gender	D.O.B.	
Other Dental Coverage ☐ Yes ☐ No	Name of other plan (if applicable)			
Marital Status				
☐ Single	☐ Domestic Partners	☐ Married	☐ Divorced/Widow	
Spouse/Domestic Partner				
Last Name, First Name		Gender	D.O.B.	
Dependents To Be Covered - *Dependent eligibility is governed by your group's contract. Please see your benefit administrator if you have questions.*				
Last Name, First Name		Gender	D.O.B.	
Last Name, First Name		Gender	D.O.B.	
Last Name, First Name		Gender	D.O.B.	
Last Name, First Name		Gender	D.O.B.	
Last Name, First Name		Gender	D.O.B.	

I agree to abide by the terms and conditions of the contract.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Signature	Date

Healthplex, Inc.

333 Earle Ovington Blvd., Suite 300 ◆ Uniondale, New York 11553-3608 ◆ healthplex.com

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