



Employer, Group or Association		Plan Choice (Please select only one plan) <input type="checkbox"/> Basic Option <input type="checkbox"/> High Option	
Subscriber's Legal Name (First Name , Middle Initial , Last Name)		Social Security #	Sex (M,F)
Address (city, state, zip)			
Work Phone	Home Phone	Cell Phone	
Date of Birth	Email Address		
Florida Dental Benefits Participating Dentist Selection (Office/Provider Name). Please visit www.FDBenefits.com for a listing of participating dentists.			

List all dependents to be covered under this policy:

Name (First, MI, Last)	Relationship	Date of Birth	Office/Provider

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or any application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Subscriber Signature	Date
-----------------------------	-------------

801 Arthur Godfrey Road, Suite 300, Miami Beach, FL 33140
Phone: (305) 674-7900 ♦ Toll Free: (877) 674-7901 ♦ Fax: (305) 674-7999