



DENTAL ENROLLMENT FORM

Benefit Administrator's Inc. (BAI)

Last Name	First Name	MI	<input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number
Address	City	State	Zip Code	Date of Birth

Coverage For: Single Widow Employee Only
 Married Divorced or Separated Employee and Dependents

Dependent/s (Complete this section only if electing to cover your dependents)				
Name/s	Social Security Number	Relationship	Date of Birth	Sex

Is your spouse employed? Yes No

If yes, please indicate his/her employer's name and address:

If yes, please indicate his/her employer's carrier/TPA providing dental coverage:

I authorize Gannon to deduct from my pay any contributions required by me in order to be enrolled in the BAI Dental Plan.

I elect not to cover my dependents under the BAI Dental Plan.

Employee Signature

Date (Month/Day/Year)

Authorized Employer Signature and Title

Date

Employer's Statement		
Effective Date of Coverage	Effective Date of FT Hire	Occupation