California DENTAL
A DENTAL HEALTH PLAN

ENROLLMENT APPLICATION

Please print or type.

Effective Date:	Group #

Social Security No.	Last Name	First	Initial	Birthday	Home Phone
				/ /	( )

Address	City	State	Zip	*Language

Employer's Name	Work Telephone
	( )

Dependents to be covered: *Please indicate Preferred Language other than English for Communications with Plan.

	Last Name (if different)	First	Birthday	*Language
Spouse:			/ /	
Child:			/ /	
Child:			/ /	
Child:				
Child:			/ /	
Child:			/ /	

Plan

Dental Office #

On behalf of the above named individuals, I hereby apply for enrollment in CDN and certify that the above information is true and correct.
NOTICE: BY SIGNING THIS APPLICATION YOU ARE AGREEING TO HAVE ANY DISPUTE WITH THE PLAN, INCLUDING MEDICAL MAL-PRACTICE, DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR CONSTITUTIONAL RIGHT TO A JURY OR COURT TRIAL. SEE THE COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM FOR DETAILS.

REQUIRED

Applicant's Signature **Date**

Availability of Language Assistance Services: If you, or a member of your family, covered by California Dental Network, cannot speak, read or write English well enough to understand information received from California Dental Network, or to communicate with your dentist, dental office, or California Dental Network about your dental coverage and treatment, then you may request free language assistance. Call, mail or fax the plan, or go online at the plan's website.

Disponibilidad de Servicios de Asistencia de Lenguaje: Si usted o un miembro de su familia cubierto por un Plan de California Dental Network no hablen, leen o escriben el Inglés con suficiente aptitud para entender la información recibida del California Dental Network, o para comunicarse con su dentista, oficina dental o con California Dental Network sobre su plan y cobertura dental, entonces usted puede comunicarse, sin costo alguno pro ese servicio. Llame, mande por correo o por fax al plan, o visite el sitio de internet del plan.