

State Employee Enrollment Form

For Office Use Only:

DS 1D DSB1D DPA1D
DS 2D DSB2D DPA2D

REQUIRED (Your Department and Division Name):

Part 1	Effective Date:		
	2. SOCIAL SECURITY NUMBER	3. NAME (LAST) (FIRST)	
	4. ADDRESS		
	(CITY)	(STATE)	(ZIP CODE)
	5. WORK PHONE	6. HOME PHONE	7. DATE OF BIRTH (month/day/year)

9. DEPENDANT INFORMATION - LIST ALL ELIGIBLE DEPENDANTS YOU WISH COVERED.

		DATE OF BIRTH	SEX	RELATION TO APPLICANT
Part 2				

Part 3	DHMO PLAN SELECT PROVIDER:	OFFICE LOCATION #
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Part 4	Select coverage	DHMO	
	<input type="radio"/> Employee Only	\$6.50	
	<input type="radio"/> Employee + 1	\$10.00	
	<input type="radio"/> Employee + Family	\$12.50	

Part 5	PAYROLL DEDUCTION AUTHORIZATION:		
	I have read and understand the terms and conditions of the program and hereby request membership with Dental Source of Missouri & Kansas, Inc. I further authorize my employer to deduct from my salary the monthly membership fees for the Dental Source coverage that I have selected.		
	SIGNATURE		DATE
	<input type="radio"/> I will NOT be participating in the State 125 Cafeteria Plan		

Part 6	<input type="radio"/> TERMINATE EXISTING COVERAGE	
	SIGNATURE	DATE

Please return form to:
Dental Source of MO & KS
12946 Dairy Ashford, Ste. 360
Sugar Land, TX 77478 Fax 281-313-7155

This payroll deduction program is not sponsored by the State and is not affiliated with the State MCHCP plans.