Dental Source of MO & KS, Inc.

State Employee Enrollment Form

For Office Use Only:
DSP1D

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)	8. SEX: Circle one Female Male

9. DEPENDENT INFORMATION - LIST ALL ELIGIBLE DEPENDENTS YOU WISH COVERED.

Part 2

	DATE OF BIRTH	SEX	RELATION TO APPLICANT

Part 3
(Semi-monthly rates)

Select a plan and coverage type.		○ **PREMIER**
○ Emp Only		$14.93
○ Emp + 1		$28.05
○ Emp + Fam		$43.71

Part 4

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**

In order to provide takeover benefits, your employer's current dental plan must have been in effect continuously for at least 12 months prior to the effective date of this plan. You MUST submit a copy of your current coverage ID card with this enrollment _____ **INITIAL** _____ **DATE**

Agent : Writing Agent _____
Name

_____
Agent Number

Agency: GAMO21355 Worksite Innovations Inc.
Bryan C. Swyers

Please return form to:
2429 Hyde Park, Jefferson City, MO 65109
Fax: 573-636-3263
Email: dental@mo-wsi.com

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