Dental Source of MO & KS, Inc.
Toll Free 1-866-481-9473
www.densource.com

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)	8. SEX: Circle one Female Male

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

Part 2

	DATE OF BIRTH	SEX	RELATION TO APPLICANT

Part 3

SELECTED DENTAL LOCATION NAME

FOR DHMO PLAN ONLY

OFFICE LOCATION #

Part 4

Select a plan and coverage type.	○ **PRE A 2009**
○ Employee Only	$9.50
○ Employee + 1	$19.00
○ Employee + Family	$29.50

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

○ I will NOT be participating in the State 125 Cafeteria Plan

Part 6

○ **TERMINATE EXISTING COVERAGE**

SIGNATURE DATE

Please return form to: **Dental Source of MO & KS, Inc.**
101 Parklane Blvd Ste. 301
Sugar Land, TX 77478
Fax (832) 415-0379

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