

Presidential Life Insurance Co.  
69 Lydecker Street  
Nyack, New York 10960  
Phone: 800-926-7599



**DENTAL INSURANCE  
ENROLLMENT AND CHANGE FORM**

Contact Our Administrative Offices:  
Pro Benefits Administrators  
100 Corporate Pkwy, Suite 342  
Amherst, New York 14226  
Phone: 888-683-3682

**Part A – Enrollment Information**

1. <b>Policyholder Name</b> (Company Name)	2. <b>Division</b>	3. <b>Effective Date:</b>
4. <b>Policyholder Street Address</b>	5. <b>Hire Date</b>	6. <b>Gender</b> ( <i>check one</i> ) <input type="checkbox"/> Male <input type="checkbox"/> Female
7. <b>Employee's Name</b> (Last, First, MI) <input type="checkbox"/> Mr. <input type="checkbox"/> Miss <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	8. <b>Birth Date</b>	9. <b>SS#</b>
10. <b>Employee's Address (Incl. Apt. No.):</b>  Address: _____  City: _____ State _____ Zip Code _____	11. <b>Check One:</b> <input type="checkbox"/> New Applicant <input type="checkbox"/> Change <input type="checkbox"/> COBRA Eff. Date: _____	
	12. <b>Home Phone</b>	
	13. <b>Coverage Requested</b> <input type="checkbox"/> SINGLE <input type="checkbox"/> EE + SPOUSE <input type="checkbox"/> EE + CHILD <input type="checkbox"/> FAMILY (EE, SPSE & CHILD)	
14. <b>Marital Status:</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated <input type="checkbox"/> Divorced		

**Part B – Dependent Information**

15. Give the following information for each dependent to be insured: Name (Last, First, MI)	Relationship	Sex	Birth Date	Full-Time Student
1.		<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No
2.		<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No
3.		<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No
4.		<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No
5.		<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No
6.		<input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Yes <input type="checkbox"/> No

Are any dependent children adopted?  Yes  No If "Yes", indicate name and date of adoption: \_\_\_\_\_

Have you included step-children as dependents?  Yes  No If "Yes", indicate name is: \_\_\_\_\_

Do your step-children reside with you?  Yes  No  
Are they dependent upon you for support and maintenance?  Yes  No

Are any of your children handicapped?  Yes  No If "Yes", indicate name is: \_\_\_\_\_

**Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.**

X \_\_\_\_\_  
Signature of Employee

\_\_\_\_\_ Date