



Redwood Health Services

Return this form to your employer, not to RHS.

Enrollment Application for Dental/Vision Coverage

Employee Information				
Social Security Number:	Date of Birth:	Date of Hire:	Gender	Coverage
			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Dental <input type="checkbox"/> Vision
Last Name		First Name		MI
Home Address:				
City:			State:	Zip Code:
Home Phone:		Work Phone:		
Mailing Address (if different from home):				

Employer Use Only					
Group Number	Effective Date			Employer (Name of Company)	
	MONTH	DAY	YEAR		
Employment Status	Date of Hire			<input type="checkbox"/> Initial Enrollment	COBRA Effective Date:
<input type="checkbox"/> Actively Employed	MONTH	DAY	YEAR	<input type="checkbox"/> COBRA Continuation	MONTH DAY YEAR
<input type="checkbox"/> Retired				<input type="checkbox"/> 18 months <input type="checkbox"/> 36 months	

List below: All dependents covered by this enrollment. Only your spouse and eligible unmarried dependents may be included.							
Social Security Number:	Last Name:	First Name:	MI	Relationship	Date of Birth	Gender	FT Student
						<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N
						<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N
						<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N
						<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N
						<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N
						<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N

If eligible family members are covered by other dental or vision insurance, please so indicate.	
Are you or any of your dependents currently covered by another dental or vision plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, name of the employee covered on the other policy:	
Name(s) of the family member(s) covered on the other policy:	
Name of the insurance company:	Name of the employer:
Effective date:	SS# of the policyholder:

I represent that the above information is true and I hereby authorize payroll deductions from my earnings for any contributions or fees as may be required to maintain my eligibility.

Signature: _____ Date: _____