DIRECT DENTAL ADMINISTRATORS, LLC

ENROLLMENT & CHANGE FORM

TO ENSURE PROPER ENROLLMENT PLEASE COMPLETE THIS FORM IN FULL

Call Member Services	855-844-0626
Email Form Using Secure Email To	enrollment@skygenusa.com
Fax This Form To	866-849-2038
Call Portal Support At	844-275-8758
Website	www.directdentalplans.com

1. COMPANY NAME			2. EFFECTIVE DATE	3. DATE OF HIRE
4. SSN	5. LAST NAME (SUBSCRIBER)	6. FIRST NAME	7. DOB	8. SEX (M/F)
9. ADDRESS	10. CITY		11. STATE	12. ZIP

BENEFIT PLANS

13. SELECT YOUR BENEFIT PLAN(S):

13A. DENTAL (Y/N)	13B. PLAN NAME	13C. COBRA (Y/N)
13D. VISION (Y/N)	13E. PLAN NAME	13F. COBRA (Y/N)

DEPENDENTS (PLEASE LIST ALL)

14. FIRST NAME	15. LAST NAME (if different)	16. DOB	17. ADDRESS (if different)	18. BENEFIT (D = dental, V = vision, B = both)	17. SEX (M/F)	18. STUDENT OVER 18 (Y/N)
SPOUSE						
CHILDREN						

REASON FOR SUBMISSION

19. CHANGE REASON:

19A. NEW MEMBER ❑	19B. ADD DEPENDENTS ❑	19C. REINSTATEMENT ❑	19D. OTHER ❑
19E. NAME CHANGE ❑	19F. ADDRESS CHANGE ❑	19G. TERMINATION ❑	19F. TERMINATION DATE

I CERTIFY THAT ALL INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

NAME _____ **DATE** _____

COMPLETE THIS SECTION ONLY IF YOU ARE WAIVING COVERAGE

20. PLEASE CHECK ONE:

20A. I HAVE COVERAGE THROUGH SPOUSE ❑	20B. I HAVE OTHER DENTAL COVERAGE ❑	20C. I DO NOT HAVE OTHER DENTAL COVERAGE ❑

NAME _____ **DATE** _____