

**Dental Application:**

Questions – Call 866-847-5820

Mail completed form to:  
 NEBCO / Chrysler Group LLC Retirees  
 50 Whitecap Drive  
 North Kingstown, RI 02852

**FOR COMPANY USE ONLY**

Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Plan Code: \_\_\_\_\_

**APPLICANT INFORMATION (PLEASE PRINT CLEARLY)**

Last Name		First Name		Initial	Birth Date (M/D/Y): / /
Address		City	State	Zip	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single
Telephone Number		Social Security Number		Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Billing Address (If Different)			City	State	Zip
Spouse's Name (First, Last, Middle Initial)				Spouse's Social Security Number	

**LIST ALL OF YOUR ELIGIBLE DEPENDENTS BELOW**

Last Name (If Different)	First Name	Initial	Sex M/F	Age	Birth Date M/D/Y

 Plan Selection:  Choice  Plus  Vision Option Coverage for:  Applicant Only  Applicant and Spouse

 Does Spouse have a dental plan:  Yes  No If yes, name of Plan: \_\_\_\_\_

By my signature below, I hereby apply for coverage under Group Dental Insurance Policy Form GH-1112 issued to the Voluntary Group Trust.  
 I also certify I have read the applicable Fraud Notice on the last page.

\_\_\_\_\_  
Applicant Signature\_\_\_\_\_  
Date

**IMPORTANT INFORMATION** - upon receipt of your completed application you will receive a copy of your Certificate of Insurance and Identification Card(s). Do not cancel any other dental coverage you may have until you receive written confirmation from Security Life. Please allow 3-4 weeks for processing.

**FOR AGENT USE ONLY - Please Print Clearly**

Producer Name: **NEBCO**  
 Street Address: **50 WHITECAP DRIVE**  
 City: **NORTH KINGSTOWN St: RI Zip: 02852**

Phone: **1-866-847-5820**  
 GH-1112-38870