

State Employee Enrollment Form

For Office Use Only:

DS 1D DSB1D DSP1D DPA1D
DS 2D DSB2D DSP2D 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	OFFICE LOCATION #
FOR DHMO PLAN ONLY		

Part 4	Select a plan and coverage type.	<input type="radio"/> DHMO	<input type="radio"/> BASIC	<input type="radio"/> PREMIER	<input type="radio"/> PRE A 2009
	<input type="radio"/> Emp Only	\$6.50	\$7.95	\$13.82	\$9.50
	<input type="radio"/> Emp + 1	\$10.00	\$15.37	\$25.97	\$19.00
	<input type="radio"/> Emp + Fam	\$12.50	\$27.95	\$40.47	\$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
	<input type="radio"/> I will NOT be participating in the State 125 Cafeteria Plan	

Part 6	<input type="radio"/> TERMINATE EXISTING COVERAGE	
	SIGNATURE	DATE

Agent : K1019, Robert G. Tyree Agency

Please return form to:
Dental Source of MO & KS
12946 Dairy Ashford Ste. 360
Sugar Land, TX 77478 Fax 281-313-7155

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