DENTAL BENEFITS -- BASA/BTA
ENROLLMENT FORM

BRIEF EXPLANATION OF PLAN:
Presently no cost to employee. $25 deductible per person per calendar year to a maximum of $75 per family. Plan covers 60% to 80% of usual & customary charges to a maximum of $1,500 per person covered per year. Routine care covered 2x per year. Orthodontic coverage maximum payment is $500. For more detailed information please see plan book.

ENROLLMENT INFORMATION

NAME:		BIRTH DATE:		
SOCIAL SECURITY #:				
FULL ADDRESS:				
HOME PHONE:				
NAME OF SPOUSE:		EMPLOYED:	Y	N
SOCIAL SECURITY #:		BIRTH DATE:		
EMPLOYER NAME:				

Dependent Name	Disabled? Y/N	Disability Date	College? Y/N	Graduation Date	College Name