

**To Select Coverage, Follow These Simple Steps**

1. Complete the Enrollment Form.
2. Participating Dental Provider # \_\_\_\_\_
3. Choose Payment Method: - Include a check for the first payment.
  - \_\_\_\_\_ Bi-Weekly (Direct Deposit through your payroll office)
  - \_\_\_\_\_ Monthly Check Service (complete and include form)
  - \_\_\_\_\_ Quarterly Billing

<b>CompBenefits Enrollment Form</b>		
	Last Name                      First Name                      MI	Sex: _____ Male    _____ Female
Social Security #:	(Home) Street:	Date of Birth:
Date of Employment: / /	(Home) City                                      State                      Zip	Home Phone: (    )
Federal Department & Agency:	Personnel Office Phone # (    )	Work Phone: (    )
<b>IF DEPENDENT COVERAGE IS ELECTED, YOU MUST ENROLL ALL ELIGIBLE DEPENDENTS</b>		
	First Name                      M.I.                      Last Name (If different)	Sex                      Date of Birth
SPOUSE:		/ /
CHILD(REN):		/ /
		/ /
		/ /
* If the address of any child is different from the member, please show child=s address with name above.		
* If requesting coverage for a dependent child other than a son or daughter, please forward legal custody papers.		
To the best of my knowledge and belief, each of the statements and answers supplied in this form is complete and true, and constitute the sole basis for, and are the inducement for, the issuance of any insurance.		
Date _____/_____/_____	Member=s Signature: _____	

MAIL COMPLETED FORM(S) TO:  
 Mass Benefits Consultants, Inc. □ P.O. Box 828 □ Annandale, VA 22003-0828