LIBERTY Dental Plan

888-703-6999

www.libertydentalplan.com

APPLICATION FOR MEMBERSHIP

Employer's Use Only

Group # 101306 Effective Date: _____

○ COBRA Enrollment COBRA End Date: _____

Last Name	First Name	MI	Social Security Number	Birth Date

Street Address	City	State	Zip Code	Telephone	Sex

LIST ALL DEPENDENTS TO BE COVERED UNDER YOUR PLAN

	Last Name	First Name	Sex	Birth Date
Spouse/ Domestic Partner				
Child				
Child				
Child				
Child				
Child				
Child				

Bakersfield City School District

Name of Employee/Turst

Provider ID Number *Language Preference*

● New Enrollment ○ Add Dependent

○ Address Change ○ Delete Dependent

Employee E-mail Address

Employee Signature **Date**

White: LIBERTY Dentist Plan Copy Yellow: HR Copy Pink: Employee Copy