NORTHERN MINNESOTA DENTAL, INC.
P.O. Box 3023
Duluth, Minnesota 55803

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Enrollment Information Form

ISD #712 – Mt. Iron / Buhl

Date Effective: ______

Type of Coverage

Group No.: **1007**

_____ Single Coverage
_____ Family Coverage

_____ New Employee
_____ Change of Address or Change in Coverage

Employee Information

♦ **Last Name:** ______

♦ **First Name:** ______ ♦ **Middle Initial:** ___

Sex ______ **Birth Date** ______
Social Security No. ______

♦ **Home Address:** ______ ♦ **Phone No.:** ______

♦ **City:** ______ ♦ **State:** ______ ♦ **Zip:** ______

If you selected family coverage, please complete the information below:

Is Spouse Employed? Yes No

♦ **Spouse Name:** ______

♦ **Birth Date:** ______ ♦ **Social Security No.:** ______

Other Dental Insurance? Yes No

♦ **Employer Name:** ______

♦ **Insurance Company:** ______

Please complete the dependent information below (if you need additional space, please use the back of this form)*:

♦ **Child Name:** ______ ♦ **Sex:** ______
♦ **Birth Date:** ______ ♦ **Social Security No.:** ______

♦ **Child Name:** ______ ♦ **Sex:** ______
♦ **Birth Date:** ______ ♦ **Social Security No.:** ______

♦ **Child Name:** ______ ♦ **Sex:** ______
♦ **Birth Date:** ______ ♦ **Social Security No.:** ______

♦ **Child Name:** ______ ♦ **Sex:** ______
♦ **Birth Date:** ______ ♦ **Social Security No.:** ______

* *A dependent child shall continue to be eligible for coverage until the age of twenty-five (25) if the child is unmarried and not regularly employed on a full-time basis.*