Registration Form • Please Print

APPLICANT NAME *(please print)* DATE OF BIRTH

STREET ADDRESS SOCIAL SECURITY NO.

CITY ZIP CODE ( ) TELEPHONE EMPLOYER OR GROUP NAME

DEPENDENTS NAMES *Spouse and Children under 19 are eligible dependents*	SOCIAL SECURITY NO.	DATE OF BIRTH
1.		
2.		
3.		
4.		
5.		

Are you or any member of your family covered by another dental insurance? ☐ YES ☐ NO If so please state name/group No.

GDP DENTAL OFFICE DESIRED (Please include address)

SIGNATURE DATE

LAKELAND UNDERWRITERS

Print Date: 9-2000