ENROLLMENT & PARTICIPATION FORM

The undersigned herby became an enrolled contributing employer in the Chamber of Commerce Dental plan for the purpose of securing group dental insurance for its employees, with all privileges and benefits there under.

1. Company Name FULTON MONTGOMERY REG. CHAMBER	Plan # 287432		2. Div. # 06
3. Contact Person	4. Telephone #		
5. Street Address	City	State	Zip
6. Mailing Address, if different from Street Address	City	State	Zip
7. Type of Business	8. Federal Tax ID #		
9. # of eligible employees (working at least 35 hours per week):			
10. # of eligible employees applying for dental?			
11. Does this plan replace another dental plan?	12. If yes, attach current plan bill & specifications		
13. Chamber Member Effective date	14. Requested Effective date of insurance		
15. Billing Mode: Quarterly Premium=	(Make check payable to Chamber)		

Authorized Signature Title

Date

For Guardian Use Only:
Verification of Effec. Date:
Verification of Participation:
Open Enrollment: Yes or No
Distribution: Premium & Billing
Issue Dept.

Participation Requirements:

1-4 eligible employees – 100% participation required
5-49 eligible employees – 75% participation required