

# CIGNA Dental Coverage Enrollment Form

## Personal Plans

Complete the enrollment form in ink and retain a copy of the completed form for your records.

### 1. APPLICANT INFORMATION

Participant name: \_\_\_\_\_ Social Security number: \_\_\_\_\_

Daytime telephone: ( \_\_\_\_\_ ) \_\_\_\_\_ Gender:  Male  Female Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Home address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Employer name: \_\_\_\_\_ Account number: \_\_\_\_\_

Work address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Work telephone: ( \_\_\_\_\_ ) \_\_\_\_\_

### 2. SELECT A PLAN OPTION

- Premier Dental Care Plan       Choice Dental Care Plan
- Guided Dental HMO Plan (Available in selected areas only. If selecting this plan, indicate a dental office number below for each covered dependent.)

### 3. LIST ALL FAMILY MEMBERS TO BE COVERED

Last name	First name	Social Security number	Relationship	Birth date	Male/female	Dental office number Guided Dental HMO Plan
		_____	Self	_____	_____	

To the best of my knowledge and belief, each of the statements and answers supplied in this form is complete and true, and they constitute the sole basis for, and are the inducement for, the issuance of any insurance.

Applicant signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

#### GUIDESTONE USE ONLY

Processed by: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Coverage effective date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Return this Authorization to:

GuideStone Financial Resources  
Insurance Operations — Personal Plans  
2401 Cedar Springs Road  
Dallas, TX 75201-1498

You may also fax this form to GuideStone at 214-720-2105.

