

**Denplan application form**

This form is for the purpose of applying for a Denplan dental cover. Cover will commence the first full month after receipt of a completed application.

|  |  |
| --- | --- |
| Name: |  |
| Payroll number: |  |
| Department: | Chief Execs / Delivery / PPR / People / Resources \* |
| Phone number: |  |
| Email address: |  |
| Postal address: |  |
| Date of birth: |  |

\*Delete as appropriate

**Cover details**

|  |  |
| --- | --- |
| Level of cover: | Key / Elementary / Essential / Essential Plus / Extensive / Extensive Plus\* |
| Cover will be for: | Single person (ie you) / Couple / Single parent / Family\* |

\*Delete as appropriate

**Dependent details** (if applicable)

This area is for your family members and you do not need to include yourself.

|  |  |
| --- | --- |
| First dependent to be covered | Name:  Date of birth: |
| Second dependent to be covered | Name:  Date of birth: |
| Second dependent to be covered | Name:  Date of birth: |
| Third dependent to be covered | Name:  Date of birth: |
| Fourth dependent to be covered | Name:  Date of birth: |

**Declaration:**

I wish to have Denplan cover as above and agree to the appropriate deduction of the amount given above to be deducted from my salary per month.

Signed …………………………………………..

Dated ……………………………………………