Existing ODAWT Group #: ______________________________

Dentist Name: ____

_________________ Minimum # hours required per week to be eligible*

_________________ Probationary Period*

_________________ Employer Contribution*

Employee Name: ____

Date of Hire: ____

Eligibility Date: ____

If beyond eligibility date, a qualifying event is required.

Where have you previously been covered? ____

Provide date prior coverage ended. ____

Why did/is prior coverage end(ing)? ____

Documentation to confirm the date/reason coverage is or was terminated is required from the carrier or employer where you were previously covered.

*Per the ODAWT Participation Form on file.