Alberta Health Services

Public Health Dental Clinics Program

Dental Insurance Plan Information

Dear Employer:

Please provide information about Group Dental insurance coverage for:

Employee complete this section:		
Employee Name *(print)*		
Company Name	Phone	
Employer complete this section:		
1. Do you offer a group dental insurance plan to employees?	☐ Yes	☐ No
If yes, does the company pay some of the cost of dental insurance premiums?	☐ Yes	☐ No
2. This employee is, or will be, eligible for a dental insurance plan Date Eligible _____	☐ Yes	☐ No
The employee's dependants are, or will be, eligible for coverage by the dental insurance plan Date Eligible _____	☐ Yes	☐ No
Comment	Date *(yyyy-Mon-dd)*	
Completed by (print)	Signature	
Official Title	Telephone	

Employer **Please return this completed form to employee.**

Employee **Please return this form to the dental clinic.**

Please return this letter to the student. Thank you for your cooperation. If you have any questions about this form, please call the Public Health Dental Clinics at 403.955.6888

For Dental Public Health Clinics Program Use Only

Surname: _____ Site: SMCHC NE Date *(yyyy-Mon-dd)*