

Enrollment/Change/Waiver Form



Employers Name: _____ GROUP # _____

PLEASE PRINT ALL REQUESTED INFORMATION

1. TO ENROLL (Complete Section 1 and sign below)

Employee's Name: _____
(Last, First, MI)

Date of Birth _____ Cobra - Termination Date _____
(Mo/Day/Yr)

Residence State _____ Zip _____

Division _____ Occupation _____

Date of Full Time Hire _____
(Mo/Day/Yr)

Male Female Social Sec. # _____ - _____ - _____

Marital Status: Single Married Divorced Widowed

Electing Coverage for: Myself Spouse Child(ren)

If declining coverage for yourself or dependents, complete section 3 also.

DEPENDENT COVERAGE INFORMATION (List all Eligible Dependents to be added or deleted)

| Print Full Legal Name (Last, First, MI) | Date of Birth (Mo, Day, Yr) | Add | Drop | Relationship |
|---|-----------------------------|--------------------------|--------------------------|--------------|
| 1 _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 2 _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| 3 _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

2. TO CHANGE NAME OR ADD/DROP DEPENDENT COVERAGE

(Complete Sections 1 & 2 and sign below)

New Name _____ Old Name _____

If Due to Marriage, what is the Date of Marriage? _____

If due to Birth/Adoption of a child, what is the Date of Event? _____

If due to Loss of coverage, Date and Reason _____ (Proof Required)

Other, the Date of Event and Please Explain _____

Drop Dependent Coverage

Drop Coverage on: Spouse Child(ren) Give reason below

Due to Divorce - Date _____ Due to Death - Date _____

Other Dental Coverage elsewhere No longer student or over age

Due to Annual Election Period

3. TO WAIVE COVERAGE (Complete Section 3 and sign below)

Declining coverage for: Myself Spouse Child(ren)

Important! If declining coverage on yourself or dependents please complete one of the reasons below and sign at the bottom:

I have been given the opportunity to apply for this dental coverage offered by my employer and have decided not to accept this offer for myself or my dependents because:

I have coverage elsewhere. Provide name of insurance company: _____

Other. Reason: _____

Should I desire to apply for coverage at a later date, I will be enrolled with limitations unless I can provide satisfactory proof of prior coverage approved by the insurance carrier, the benefits will be issued standard. If electing coverage provided by my employer, I authorize deductions from my earnings of the required contributions, if any, toward the cost of this insurance. Authorization is only necessary if employee contributions are required.

PLEASE SIGN (EMPLOYEE SIGNATURE)

Employee Signature Date

Print Name: _____