enrollment/change/waiver
group insurance form

COBRA: If individual is a continuee

Qualifying Event _____

Date of Event _____

Policy and Div. # **026-**_____   Cert. #_____

Name and Address of Employer (Policyholder) _____

1 **to enroll**   ☐ **Dental**   ☐ **Vision**   ☐ To terminate all coverages

employee information   Marital Status ☐ Single ☐ Married

Social Security number _____   Dept. number _____

Employee's last name, first name, MI _____

Date of birth _____   ☐ Male ☐ Female

Full time date of hire _____   ☐ Rehire: Rehire date _____

Occupation _____

Hours worked each week _____   Are your earnings paid: ☐ Hourly or ☐ Salaried

Street address _____   City_____   State_____ ZIP_____

E-mail address (limit of 60 characters) _____

Are you covered under another **dental** insurance plan? . . . . **Employee:** ☐ Yes ☐ No   **Dependents:** ☐ Yes ☐ No

Are you covered under another **vision** insurance plan? . . . . **Employee:** ☐ Yes ☐ No   **Dependents:** ☐ Yes ☐ No

dependent coverage information   List all eligible dependents to be added or deleted. (Employee must be enrolled to cover dependents)

print full legal name (last, first. MI)	add	drop	relationship	sex	date of birth	social security number
1						
2						
3						
4						
5						

please sign (employee/policyholder) **The certificate provides dental and vision benefits only. Review your certificate carefully.**
As an employee, I hereby apply for, or waive (if indicated), group insurance, for which I am eligible or may become eligible. If contributions are required, I authorize my employer to deduct premiums from my salary. *THE FOLLOWING APPLIES ONLY TO SECTION 125 FLEXIBLE BENEFITS PLANS:* I am signing up for coverage until the next enrollment period except in the case of a life event. This information was explained in the plan's solicitation materials which I have read and understand. I represent that the information I have provided is complete and accurate to the best of my knowledge. The policyholder certifies the date of employment, job title, hours worked and salary information are correct according to the Policyholder's records.

X_____   **X**_____
Employee Signature (do not print)   Date   Policyholder Signature (do not print)   Date

Any person who knowingly and with intent to defraud any insurance company or other reason files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five-thousand dollars and the stated value of the claim for each such violation.

Employee late entrant date _____

Dependent late entrant date _____

Effective Date	Class	Dep. Code

2 **to change**

☐ **Name change**   New Name _____   Old Name_____

☐ **Add dependent coverage**

  ☐ If due to marriage, what is the date of marriage? _____

  ☐ If due to birth/adoption, what is the date of event?_____

  ☐ If due to loss of coverage, date and reason: _____

  ☐ If other, the date of event and please explain: _____

☐ **Drop dependent coverage**   Number of dependents still covered: _____   Effective date of drop: _____

  ☐ Due to divorce   ☐ Due to death   ☐ Due to annual election period

  ☐ Other (please explain)_____

3 **to waive**   IF YOU DO NOT WANT COVERAGE, COMPLETE THE WAIVER SECTION. THE WAIVER MAY NOT BE ALLOWED FOR THIS PLAN, CHECK WITH YOUR EMPLOYER. I have been given an opportunity to apply for Group Insurance offered by my employer, and have decided not to accept the offer for:

  ☐ **myself** (does not apply to TRUST policies)   ☐ **spouse only**   ☐ **child(ren) only**   ☐ **spouse and child(ren)**

because _____

Name of insurance company and employer of dependent _____

Should I desire to apply for this group insurance in the future, I realize that a "late entrant" penalty may be applied.

Tips

for filling out this form

To enroll

Missing, incomplete or illegible information can cause delays in adding new employees to the system and could create errors in billing. To ensure proper handling of your enrollment forms, please make sure the following areas are completed:

Policy Name and Group Number – to make sure plan members are added to the correct group.

Department/Division Numbers – so plan members are added in the proper locations, and appear in the appropriate section on the billing if the group has multiple departments or divisions.

Social Security Numbers – the most important identifier for plan members when calling in with claims or administrative questions. Please double check to make sure your social security number is accurate and written clearly.

Full-time Employment Date – needed so the correct effective date is calculated for new members.

Class Number – needed when the plan has more than one class of employees.

To change

Changing Dependent Codes – When adding or dropping dependents, please note whether this change is because of a "life event" or for some other reason. (Examples of life events: marriage, birth of a child, divorce . . .) Please remember to include the date of the event. Late entrant status will be applied if a life event is not included. Be specific when changing status so all dependents who are still eligible will be covered.

Imaging

In order to provide better service, our administration system utilizes image technology. In the image environment, we scan your enrollment forms into our system, making them easier and faster to access. Better quality forms help us to process your enrollments faster. Unfortunately, certain forms are difficult or impossible to scan. The following list of helpful hints will make your forms easier to scan:

Do:
1) submit clear, legible enrollment forms.
2) underline or circle important information.
3) use blue or black ink.

Don't:
1) submit dark copies as they appear black on imaging.
2) highlight, which blackens the area so it cannot be read.
3) write on the top or bottom margins. This information is not always captured on the image system.