

GENERAL INFORMATION

COMPANY/EMPLOYER NAME				DIVISION/LOCATION			
SUBSCRIBER/EMPLOYEE NAME (LAST, FIRST, MIDDLE INITIAL)				SOCIAL SECURITY NUMBER			
ADDRESS: STREET			CITY		STATE		ZIP
DATE OF BIRTH MO DAY YEAR	DATE HIRED FULL TIME MO DAY YEAR	<input type="checkbox"/> NEW SUBSCRIBER/EMPLOYEE <input type="checkbox"/> REHIRED SUBSCRIBER/EMPLOYEE	<input type="checkbox"/> SPECIAL ENROLLEE <input type="checkbox"/> OPEN ENROLLMENT	MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> WIDOWED <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	

COVERAGE ELECTION - DENTAL

SUBSCRIBER/EMPLOYEE		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	ORIGINAL DATE OF COVERAGE MO DAY YEAR	DATE OF BIRTH MO DAY YEAR
Are you covered under any other dental plan? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, name of other carrier and policy number				
SPOUSE		SPOUSE SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	ORIGINAL DATE OF COVERAGE MO DAY YEAR	SPOUSE DATE OF BIRTH MO DAY YEAR
Is your spouse covered under any other dental plan? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, name of other carrier and policy number				
DEPENDENT CHILD		CHILD SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	ORIGINAL DATE OF COVERAGE MO DAY YEAR	CHILD DATE OF BIRTH MO DAY YEAR
Is your child covered under any other dental plan? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, name of other carrier and policy number				
DEPENDENT CHILD		CHILD SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	ORIGINAL DATE OF COVERAGE MO DAY YEAR	CHILD DATE OF BIRTH MO DAY YEAR
Is your child covered under any other dental plan? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, name of other carrier and policy number				
DEPENDENT CHILD		CHILD SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	ORIGINAL DATE OF COVERAGE MO DAY YEAR	CHILD DATE OF BIRTH MO DAY YEAR
Is your child covered under any other dental plan? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, name of other carrier and policy number				
DEPENDENT CHILD		CHILD SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	ORIGINAL DATE OF COVERAGE MO DAY YEAR	CHILD DATE OF BIRTH MO DAY YEAR
Is your child covered under any other dental plan? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, name of other carrier and policy number				

DECLINATION OF COVERAGE

**I DECLINE ENROLLMENT FOR:**

MYSELF (I HAVE NO ELIGIBLE DEPENDENTS)  
 MYSELF AND MY ELIGIBLE DEPENDENTS  
 MY ELIGIBLE DEPENDENTS

SIGNATURE OF SUBSCRIBER/EMPLOYEE \_\_\_\_\_ DATE SIGNED \_\_\_\_\_

I hereby apply for self-funded and/or insurance coverage. I agree the copy of my signature or copy of this form may be accepted as my signature. I authorize necessary deductions from my salary, account or dues for any contributions required. I acknowledge that the Privacy Standards of the Health Insurance Portability and Accountability Act Regulations authorize the use and disclosure of Protected Health Information for Treatment, Payment and Health Care Operations purposes without the member's written consent. I agree that, to the best of my knowledge and belief, all statements and answers to the questions in this application are complete and true and agree that they will be the basis of the issuance of any coverage, by any underwriter or carrier. Subject to the approval of this application, the coverage applied for shall become effective in accordance with the terms of the plan document. I understand that coverage once offered and declined, may be elected at a later date (1) with respect to dental coverage, (a) under the plan document's Special Enrollment Rules. I understand that I must meet all eligibility requirements before coverage can become effective. I understand that any falsification will result in denial or cancellation of coverage so that the result is no coverage was ever in effect and any claims paid will be reimbursed by me. I acknowledge receipt of the summary plan description. I received and read a copy of the Notice of Pre-Existing Condition Exclusions and Special Enrollment Rights at or before the time I was initially offered enrollment in the health plan.

SIGNATURE OF SUBSCRIBER/EMPLOYEE \_\_\_\_\_ DATE SIGNED \_\_\_\_\_

**DO NOT COMPLETE - FOR ACS USE ONLY**

PLAN NUMBER	DIVISION NUMBER	EFFECTIVE DATE	ENROLLMENT DATE <input type="checkbox"/> 1st Day W.P. (Hire Date) <input type="checkbox"/> Effective Date	DENTAL CODE
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